

**PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS'
MOTION TO EXCLUDE EXPERT TESTIMONY FROM G. CALEB
ALEXANDER**

EXHIBIT B

G. CALEB ALEXANDER DEPOSITION TRANSCRIPT (09-18-2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

* * * * *

THE CITY OF HUNTINGTON,

Plaintiff,

vs.

CIVIL ACTION
NO. 3:17-01362

AMERISOURCEBERGEN DRUG
CORPORATION, et al.,
Defendants.

CABELL COUNTY COMMISSION,
Plaintiff,

vs.

CIVIL ACTION
NO. 3:17-01665

AMERISOURCEBERGEN DRUG
CORPORATION, et al.,

Defendants.

* * * * *

Videotaped and videoconference deposition
of DR. G. CALEB ALEXANDER taken by the Defendants
under the Federal Rules of Civil Procedure in the
above-entitled action, pursuant to notice, before
Teresa S. Evans, a Registered Merit Reporter, all
parties located remotely, on the 18th day of
September, 2020.

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BY MS. GEIST

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1 P R O C E E D I N G S

2 VIDEO OPERATOR: Good morning. We are
3 going on the record at 9:32 a.m. on September 18th,
4 2020. Please note that the microphones are
5 sensitive and may pick up whispering, private
6 conversation and cellular interference. Please
7 turn off all cell phones and place them away from
8 the microphones, as they can interfere with
9 deposition audio.

10 Audio and video recording will
11 continue unless all parties agree to go off the
12 record.

13 This is Media Unit 1 of the video
14 recorded deposition of Doctor G. Caleb Alexander
15 taken by the Defendant in the matter of the City of
16 Huntington versus AmerisourceBergen Drug
17 Corporation, et al and Cabell County Commission
18 versus AmerisourceBergen Drug Corporation, et al,
19 filed in the U.S. District Court for the Southern
20 District of West Virginia, Case Nos. 3:17-01362 and
21 3:17-01665.

22 This deposition is being held remotely
23 via Zoom conference. My name is Justin Ebeling
24 from the firm Veritext. I'm the videographer. The

1 court reporter is Teresa Evans from the firm
2 Veritext.

3 I'm not authorized to administer an
4 oath; I'm not related to the parties in this
5 action; nor am I financially interested in the
6 outcome.

7 Counsel and all present in the room
8 and everyone attending remotely will now state
9 their appearance and affiliations for the record.

10 MR. BURNETT: I'll start. This is
11 David Burnett from Motley Rice on behalf of the
12 plaintiffs, and I'm joined by Andrew Arnold from
13 Motley Rice for the Plaintiffs.

14 MS. GEIST: Mel --

15 MR. STOUT: Jacob Stout, Motley Rice,
16 Plaintiffs.

17 MS. GEIST: Sorry about that. Is that
18 it for the plaintiffs today?

19 MR. BURNETT: I see Anne Kearse is
20 logged in. I'm not sure if she's -- I'm not sure
21 if she's there, but someone logged in for her.

22 MS. GEIST: Okay, great.

23 MR. FARRELL: Yeah, Anne Kearse and
24 Paul Farrell.

1 MS. GEIST: Good morning. Melissa
2 Geist from Reed Smith for the Defendant
3 AmerisourceBergen Drug Corporation.

4 MR. FRANKS: I'm Ray Franks, local
5 counsel in Charleston, West Virginia for Cardinal
6 Health with the law firm of Carey, Douglas, Kessler
7 & Ruby. We expect that Steve Ruby will be along
8 directly.

9 VIDEO OPERATOR: Any objection to the
10 reporter administering the oath remotely?

11 MS. BURNETT: No objection.

12 THE DEPONENT: No objection.

13 VIDEO OPERATOR: Will the court
14 reporter please swear the witness.

15 (The witness was sworn.)

16 G. C A L E B A L E X A N D E R
17 was called as a witness by the Defendants, and
18 having been first duly sworn, testified as follows:

19 EXAMINATION

20 BY MS. GEIST:

21 Q. Good morning, Doctor Alexander.

22 A. Good morning.

23 Q. How are you today?

24 A. Fine, thank you.

1 Q. You get to take your mask off. Doctor
2 Alexander, would you just please state your full
3 name for the record?

4 A. George Caleb Alexander.

5 Q. And you have been retained by the
6 Plaintiffs, Cabell County and the City of
7 Huntington, in a case pending in West Virginia; is
8 that correct?

9 A. Yes, ma'am.

10 Q. And you intend to give expert testimony if
11 this case proceeds to trial next month, October
12 2020; is that correct?

13 A. It is.

14 Q. And do you anticipate providing trial
15 testimony, Doctor, live or via some remote means?

16 A. I've indicated to the plaintiffs that if
17 it's helpful for me to be there in person that I'm
18 willing to do so.

19 Q. Have you brought any materials with you to
20 your deposition today?

21 A. I have -- yes, ma'am.

22 Q. And what have you brought?

23 A. I have copies of two or three reports, as
24 well as a copy of my own report.

1 Q. And when you say "two or three reports,"
2 are you talking about other expert reports that
3 have been submitted in this case?

4 A. Yes, I am.

5 Q. Okay. And whose expert reports are those?

6 A. I have an expert report from George
7 Barrett, and I have an expert report from Nancy
8 Young.

9 Q. And you said, Doctor Alexander, you also
10 brought a copy of your own expert report?

11 A. Yes. Yes, I did.

12 Q. Did you mark up that expert report or
13 highlight it or tab it in any way?

14 A. No, I did not.

15 Q. For the record, can you tell me, please --
16 I see a grey background, but other than that, I
17 have no idea where you're physically located.
18 Would you please tell me where you are today for
19 your deposition?

20 A. Of course. I'm in a hotel in downtown
21 Baltimore. I believe it's the Hyatt Regency.

22 Q. And are you by yourself in the room?

23 A. Yes, I am.

24 Q. And plaintiffs' counsel is with you there

1 today as well, but not in same room; is that
2 correct?

3 A. Yes, that's correct. They're -- David
4 Burnett is in a room directly behind me.

5 Q. Are there any other plaintiffs' counsel -
6 either from Motley Rice or another law firm - there
7 at the hotel in Baltimore today?

8 A. No. Not that I'm aware of, no. I don't
9 believe so.

10 Q. Doctor Alexander, because this is an odd
11 setting necessitated due to the COVID pandemic, I
12 just want to ask you some specific questions before
13 we begin. And the first is: Do you have with you
14 a computer screen, an iPad, a laptop or any type of
15 device such as an iPhone to where you could access
16 the Internet?

17 A. Yes, I do.

18 Q. Okay. And what do you have there with you?

19 A. Well, I have an iPhone next to me, although
20 I've turned it off as I was requested to do, and
21 then I'm speaking to you through an Apple MacBook
22 Pro that I can use to access the Internet.

23 Q. Can you agree with me that for purposes of
24 this deposition today, that you will not send or

1 receive or review any text messages or other
2 messages on your iPhone?

3 A. Well, pertaining to the case, I presume? I
4 mean, I'm also a practicing internist, and actually
5 on call - although I have coverage for most of the
6 day - so do you mean just pertaining to this case?

7 Q. I do. What I'm trying to -- and I
8 understand, Doctor Alexander, you're a practicing
9 physician, and if you need to call back a patient
10 or there's some type of emergency, I can appreciate
11 that, and of course, we will accommodate that.

12 A. Okay.

13 Q. So can you let me know if that comes up
14 during the deposition?

15 A. Absolutely.

16 Q. Okay. So let me be more precise in my
17 question. Can you agree with me that you will not
18 communicate with counsel for the plaintiffs
19 regarding this case via e-mail, text message,
20 instant messenger or any other form of
21 communication during your deposition?

22 MR. BURNETT: Let me just interject.
23 Counsel, what is the basis for the question? Is
24 there a legal principle that you're founding that

1 request on?

2 MS. GEIST: Counsel --

3 MR. BURNETT: Just seems unusual to
4 ask that.

5 MS. GEIST: Well, I've heard it asked
6 in a number of different depositions. I think it's
7 fair to ask that the witness agree not to
8 communicate with counsel during the
9 question-and-answer period of the deposition.

10 Communications other than objections
11 are prohibited by the rules, so I'm asking if
12 Doctor Alexander will agree not to look at or send
13 any text messages, e-mails or other communications
14 that may come between him and counsel for
15 plaintiffs.

16 I think that's fair.

17 Q. Would you agree to do that, Doctor
18 Alexander?

19 A. If that's an expectation of -- of the
20 attorneys, then I'm happy to agree to do so, yes.

21 MR. BURNETT: Yeah, I'm not aware of
22 such a request in the past, so I'm going to reserve
23 rights on that issue. I mean, in principle, I
24 don't have an objection to doing that, but I'm just

1 -- I -- that's the first time ever hearing of that
2 sort of request.

3 MS. GEIST: Understood. I hear your
4 position.

5 Q. And similarly, Doctor Alexander, while your
6 deposition is being conducted, can you agree with
7 me that you will not be looking for information or
8 responses to questions by surfing the Internet?

9 A. Again, I'm happy to agree to such if that's
10 an expectation of the -- the Court's and these
11 proceedings, yes, I'm happy to agree to do -- to
12 avoid doing so.

13 Q. Again, like a regular deposition, though,
14 we will take breaks. We -- I expect we will be
15 together most of today, so it's not a marathon
16 session. I typically take a break every hour. If
17 I fail to do so and you would like to take a break,
18 would you please let me know, and I'm happy to
19 accommodate that at any time?

20 A. Absolutely, and I appreciate your noting
21 that.

22 Q. Sometimes I tend to just talk and talk and
23 talk and two hours will have gone by, so I will try
24 to take breaks every hour or so.

1 Similarly, Doctor Alexander, because
2 we're not together in the same room, I think it is
3 easier to speak over one another.

4 You are doing an excellent job right
5 now waiting for me to ask my question before you
6 begin responding. Can you please just have a
7 heightened awareness of the importance of that in
8 this Zoom remote setting?

9 A. Of course.

10 Q. Thank you. Anything at all, Doctor
11 Alexander, that would prevent you from providing
12 full and accurate and truthful testimony today?

13 A. No.

14 Q. And this is not your first deposition,
15 Doctor Alexander. Is that correct?

16 A. Yes, that's correct.

17 Q. You gave a deposition in a case on behalf
18 of plaintiffs that was in Ohio and the plaintiffs
19 were Cuyahoga and Summit Counties. Do you recall
20 that?

21 A. Yes, I do.

22 Q. Have you given any depositions as an expert
23 since that Ohio, Cuyahoga/Summit County deposition?

24 A. No, I have not.

1 Q. And was that the only expert deposition
2 that you have given in the opioids litigation on
3 behalf of plaintiffs?

4 A. Yes, it was.

5 Q. Now Doctor Alexander, I asked you
6 informally before we began on the record if you
7 have a box of documents or a box filled with sealed
8 envelopes there in the room with you, and you
9 indicated to me that you do?

10 A. Yes, I do. They're right next to me.

11 Q. Okay. And I will preface my question by
12 letting you know that I do not anticipate we're
13 going to go through every single document. So I'm
14 not sure how large your box looks, but we may not
15 go over every single document in there.

16 We're going to be jumping around a
17 little bit, so I do apologize in advance for that.

18 Did you open any of the envelopes in
19 the box or look at the documents in the box before
20 your deposition?

21 A. No, I have not.

22 Q. Why don't you go ahead, Doctor Alexander,
23 and find what should be an envelope marked as
24 either Exhibit 1 or Tab 1?

1 MR. BURNETT: It's Tab 1.

2 MS. GEIST: Thank you.

3 A. Okay, I have that in my possession.

4 Q. Great. Would you please open it for me?

5 ALEXANDER DEPOSITION EXHIBIT NO. 1

6 (Amended Notice of Remote Deposition
7 of Dr. G. Caleb Alexander dated 9-2-20
8 was marked for identification purposes
9 as Alexander Deposition Exhibit No.
10 1.)

11 VIDEO TECH: Tab 1 has been introduced
12 as Exhibit 1 on Exhibit Share.

13 Q. Okay. And hopefully -- and good, there it
14 is. Hopefully Exhibit 1 is the Amended Notice of
15 your remote deposition in this case brought by the
16 City of Huntington and Cabell County Commission.

17 And you have that in front of you,
18 Doctor?

19 A. Yes, ma'am, I do.

20 Q. And had you seen this notice before today?

21 A. I believe a copy of it was e-mailed to me
22 notifying me about this -- this event.

23 Q. And that was e-mailed to you, I presume, by
24 plaintiffs' counsel, correct?

1 A. I presume so. I suppose it's possible it
2 could have come from the -- that seems most likely.
3 I don't know if it's possible, it could have come
4 from -- is it Veritext or our colleagues that are
5 involved in recording and transcribing this, but it
6 may well have come from plaintiffs, yes.

7 Q. Okay. It doesn't really matter. Just the
8 fact that you have seen it before today. And did
9 you take a quick look and review it?

10 A. Very briefly.

11 Q. Okay. One of the things that the notice
12 does besides ask you to appear today for your
13 deposition in the case is ask you for an
14 itemization of the hours spent and expected to be
15 spent, compensation paid, in connection for your
16 expert work in this case.

17 So Doctor Alexander, can you -- can
18 you let me know, when were you retained, first of
19 all, by plaintiffs' counsel?

20 A. I don't know the date, the exact date,
21 offhand, but I would guess it was -- regarding this
22 particular case, I would guess it was possibly 12
23 to 18 months ago.

24 Q. So sometime in early to middle of 2019; is

1 that fair?

2 A. I mean, that -- that is a guess. I've been
3 involved in a lot of different opioid litigation
4 cases and I don't recall the precise date when I
5 was retained for this -- this track, but as you
6 know, this is Track 2 of the MDL, and I was
7 involved in the first case as well, etc.

8 MR. BURNETT: And Doctor Alexander,
9 let me just interject here. You should not enclose
10 any engagements of yours in any opioid litigation
11 except to the extent you've been disclosed as a
12 witness in that case.

13 And if you're not sure, because that's
14 -- if you're not sure, don't -- don't disclose and
15 we can discuss.

16 THE DEPONENT: Thank you.

17 Q. And Doctor Alexander, subject to your
18 counsel's instruction, my understanding is that you
19 are obviously retained and disclosed as an expert
20 witness for the plaintiffs in this case, City of
21 Huntington and Cabell County, correct?

22 A. Yes, ma'am.

23 Q. And you were also retained and disclosed as
24 an expert in what you referred to as the MDL case,

1 and that was brought by Cuyahoga and Summit
2 Counties in Ohio, correct?

3 A. Yes, ma'am.

4 Q. And you were also retained and disclosed in
5 connection with a case in Washington State. Is
6 that also correct?

7 A. I report in my report where I've been
8 retained and disclosed, so I would want to look
9 briefly at my report for that information --

10 Q. Okay.

11 A. -- in order to confirm that.

12 Q. And we can do that when we get to your
13 report.

14 Sitting here today, to the best of
15 your knowledge, have you been disclosed as an
16 expert witness for plaintiffs in any other
17 opioid-related case?

18 MR. BURNETT: And again, Doctor
19 Alexander, please only answer "Yes" and disclose
20 anything if you're sure that you have been
21 disclosed.

22 THE DEPONENT: Thank you.

23 A. So I -- I would want to look at my report,
24 which indicates the cases for which I've been

1 retained and disclosed.

2 Q. And that's fine, and we'll do that in a few
3 minutes just so we have accuracy. Is that fair?

4 A. Sure.

5 Q. When were you first retained by plaintiffs'
6 counsel in connection with expert work for the
7 opioids litigation?

8 MR. BURNETT: Objection.

9 A. I --

10 THE DEPONENT: Go ahead, David.

11 MR. BURNETT: Go ahead.

12 A. I presume you would be asking or I would be
13 replying regarding cases that I've been retained
14 and disclosed, and I believe the first of these
15 cases was the MDL case in Cuyahoga and Summit
16 Counties, and again, I don't have a precise
17 recollection of the -- of the month and year that I
18 was retained, but my guess would be that it was 24
19 months ago, plus or minus.

20 About two years ago. Possibly a bit
21 more.

22 Q. Now, it -- specifically for this case, can
23 you tell me how much total time you have spent in
24 connection with your expert work for plaintiffs in

1 this particular case?

2 A. Yes, I believe so.

3 Q. And what is that?

4 A. I believe I've spent about 75 hours devoted
5 to this case, but it's also important to underscore
6 that -- that I work extensively - and have worked
7 extensively - for years focusing on the opioid
8 epidemic, and so while that may represent the
9 number of hours that I've directly logged, so to
10 speak, working directly on my report, it rests upon
11 an enormous amount -- an enormous number of hours.

12 I don't know if it's, you know,
13 10,000, 15,000. I don't know how many hours. But
14 the point is that there's a lot of additional work
15 that I've done that I use to -- and incorporate
16 into the hours that I've committed to this case.

17 Q. Understood. And just by way of summary,
18 you have been very active and outspoken in terms of
19 researching, writing and speaking with respect to
20 the opioids abuse epidemic in the U.S. generally;
21 is that fair?

22 MR. BURNETT: Objection.

23 A. Well, I --

24 Q. You can answer.

1 MR. BURNETT: Go ahead.

2 A. I mean, I don't -- I have a bit of a
3 concern about framing the epidemic as one of
4 "abuse." It's really an epidemic of addiction, and
5 a lot of my work and work of others has
6 demonstrated that, so I'm happy to return to that
7 point, but I would not characterize the epidemic as
8 -- as an epidemic of abuse.

9 With that being said, it is correct
10 that -- that I've spent a lot of time working on
11 identifying evidence-based approaches to abate
12 harms that continue to accrue from opioids.

13 I don't think of myself really as
14 outspoken or -- or -- I don't recall if you used
15 the word "activist" or something like that.

16 I don't really consider myself in that
17 light, but I certainly have focused a lot of my
18 scholarship as a professor of epidemiology on
19 examining the contours of the epidemic and how we
20 can best prevent additional harms from occurring.

21 Q. And in terms of your speaking, I didn't use
22 the term "activist."

23 A. Okay.

24 Q. If I did, I didn't mean to. But fair to

1 say, you know, you have spoken at rallies, on radio
2 programs, on media programs. Is that fair?

3 A. Yes, I certainly -- I mean, I -- I think
4 that it's important that -- to disseminate the
5 scholarship that -- that originates from Johns
6 Hopkins or other academic institutions, and so
7 generally when asked, I have sought opportunities
8 to try to communicate my concerns or my beliefs
9 about where we need to go.

10 And that has included infrequently
11 speaking at conferences or rallies, but I certainly
12 have communicated with the media extensively around
13 the opioid epidemic because I believe that the
14 media plays such an important role in helping to
15 correct misunderstandings and, frankly,
16 misconceptions that have been propagated about the
17 epidemic.

18 So I certainly do look for
19 opportunities to extend my scholarship through
20 those forums.

21 Q. And in addition to speaking with the media
22 frequently on the topic, you have also published
23 quite a bit on the opioids epidemic. Is that
24 correct?

1 A. Yes, it is.

2 Q. How much of a focus of your research in the
3 last, say, five years has been devoted to the
4 opioid epidemic?

5 A. Huh. I would guess -- I mean, it's an
6 interesting question. I would guess 75 percent,
7 plus or minus.

8 Q. And is that the same percentage every year
9 for the last five years?

10 A. No. I mean, it -- I'm sure it waxes and
11 wanes. And I'm not suggesting that 75 percent of
12 my papers are epidemic-related or, you know, that
13 there's some definitive quantitative measure of
14 output that's opioid-related to gauge this.

15 It's just a Gestalt that I believe
16 about three-quarters of my scholarship has focused
17 one way or another over the past five years on
18 opioid-related matters.

19 Q. Now, you told me earlier you spent
20 approximately 75 hours on your expert work in this
21 case. Can you break out for me how many hours you
22 spent preparing your report?

23 MR. BURNETT: Counsel, I'm going to --
24 I'm going to object. You know, as you know, you're

1 -- parties are not entitled to drafts of reports,
2 and by extension, I believe you don't need to know
3 anything more than that about his process of
4 preparing his report, including, you know, how much
5 time is spent.

6 MS. GEIST: So I understand the rule
7 about drafts, Counsel, and of course, we're going
8 to abide by that rule. But I do not think I'm
9 prohibited from asking Doctor Alexander how many of
10 his 75 hours he spent actually preparing his
11 report.

12 MR. BURNETT: I'm -- I'm going to --
13 I'm going to instruct him not to answer that. And
14 we can circle back to that.

15 BY MS. GEIST:

16 Q. And I assume, Doctor Alexander, you're
17 going to heed Mr. Burnett's instruction?

18 A. Well, I mean, I -- I'm just trying to help.
19 So you know, I would prefer for you to reach
20 consensus about any matters where there's
21 disagreement, and then I am happy to go with the
22 flow.

23 Q. How much time have you spent preparing for
24 your deposition in this case?

1 A. Probably ten hours.

2 Q. And can you just explain to me generally,
3 what did you do to prepare for your deposition
4 today?

5 A. I reviewed my report and the information
6 that I've provided to the courts, and I briefly
7 reviewed other materials that are relevant to my
8 testimony, and I spoke with counsel -- with
9 plaintiffs' counsel and colleagues at Monument
10 Analytics.

11 Q. And Monument Analytics, is that your
12 consulting business, Doctor?

13 A. Yes, ma'am. I mean, it's not -- yes,
14 ma'am.

15 Q. And in terms of materials relevant to your
16 report, sitting here today, can you tell me
17 specifically what materials you reviewed in advance
18 of your deposition?

19 A. Yes, I can.

20 Q. Will you, please?

21 A. I reviewed -- briefly reviewed
22 Mr. Barrett's report and Doctor Young's report and
23 the reports from -- two reports from defendants, in
24 particular. Is it a Mr. Rufus perhaps? And

1 Ms. Colson?

2 And I watched the documentary
3 Heroin(e), which is a Netflix documentary about
4 Cabell County and the City of Huntington. And
5 those are the -- those are the materials that I
6 reviewed in preparing for this deposition.

7 Q. Okay. So just to make sure I -- and did
8 you also meet with counsel, by the way, either by
9 phone or in person?

10 A. I did. I'm sorry, I thought that I
11 included that in -- in my last reply. But yet, I
12 met and had conversations with counsel and with
13 colleagues from Monument Analytics.

14 Q. And with respect to counsel, who did you
15 meet with, and when did you have the meeting?

16 A. David Burnett and Andrew Arnold. And we
17 met yesterday.

18 Q. And in terms of speaking with your
19 colleagues at Analytics, who did you speak with?
20 I'm sorry, Monument Analytics. Who did you speak
21 with at Monument Analytics in advance of your
22 deposition?

23 A. Omar Mansour and Katherine Ozenberger.
24 Mansour is M, like Mary, A-N, S like Sam, O-U-R;

1 and Katherine Ozenberger. I believe her last name
2 is spelled O like Oscar, Z like zebra, E-N like
3 Nancy, B like boy, E like Edward, R like Robert, G,
4 E like Edward, R like Robert.

5 Q. When you spoke with Mr. Mansour and
6 Ms. Kozenberger --

7 A. Ozenberger.

8 Q. -- I'm sorry, Ozenberger. When you spoke
9 with Mr. Mansour and Ms. Ozenberger, did you do
10 that in the presence of plaintiffs' counsel?

11 A. Yes and no. In other words, I had
12 conversations with them when plaintiffs' counsel
13 weren't present, and I had conversations with them
14 when plaintiffs' counsel was present.

15 Q. And this was in preparation for your
16 deposition; is that right?

17 A. Yes, ma'am.

18 Q. Okay. What was the substance of your
19 conversations with them, Ms. Ozenberger and
20 Mr. Mansour, in preparation your deposition where
21 counsel was not present?

22 A. We discussed the reports from Mr. Rufus and
23 Ms. Colson, is it, and we discussed those reports,
24 as well as reviewed my -- my report.

1 Q. And how long did -- was that --

2 MS. GEIST: Strike that.

3 Q. Was that one meeting, or multiple meetings?

4 A. I believe it was two meetings.

5 Q. And do you know how long those meetings
6 lasted?

7 A. I believe both were approximately two
8 hours.

9 Q. Two hours each?

10 A. Yes, ma'am.

11 Q. And did you take any notes during those
12 meetings?

13 A. I did, yes.

14 Q. And did you bring those notes with you
15 today?

16 A. I mean, they're on my hard drive, but I
17 didn't -- I don't have printouts of them.

18 Q. And what was the purpose of speaking with
19 Mr. Mansour and Ms. Ozenberger regarding the
20 reports from Mr. Rufus and Ms. Colson?

21 MR. BURNETT: Counsel, let me just
22 interject here. You know, it -- Doctor Alexander
23 's preparation for this deposition, the whole thing
24 is sort of -- you know, even if he wasn't

1 explicitly talking with counsel on a particular
2 conversation, the whole process is suffused with
3 our, you know, privilege and work product concerns,
4 so I'm a little concerned about you asking so much
5 detail about his preparation for this deposition,
6 given that a lot of it did involve counsel.

7 MS. GEIST: So Mr. Burnett, I think
8 that Doctor Alexander was very clear. He indicated
9 that some of his preparation involved discussions
10 with counsel; some of his preparation involved
11 discussions with two individuals from Monument
12 Analytics that were with counsel present; and there
13 were also discussions with the individuals at
14 Monument Analytics where counsel was not present.

15 So I'm entitled to explore the
16 substance and discussions that occurred during
17 those meetings.

18 MR. BURNETT: I understand that. I'm
19 just saying that there may be an argument that even
20 for those conversations, there's still some
21 implication of -- of work product or privileged
22 information.

23 MS. GEIST: Well --

24 MR. BURNETT: So I'm just preserving

1 an objection on that -- on that basis.

2 MS. GEIST: You're not instructing him
3 not to answer? Is that correct?

4 MR. BURNETT: I would have to hear the
5 question again.

6 MS. GEIST: Okay.

7 Q. So the question is: You met with
8 Mr. Mansour and Ms. Ozenberger to discuss the
9 reports that have been submitted on behalf of the
10 defendants, Mr. Rufus and Ms. Colson without
11 counsel present.

12 Is that correct, Doctor Alexander?

13 A. Yes, it is.

14 Q. And why did you do that?

15 A. For the same reason that I met with counsel
16 yesterday, which is -- I'm sorry.

17 -- which is to ensure that --

18 MR. BURNETT: Again -- sorry, let me
19 just interject. With regard to the conversation
20 that you had with me and counsel yesterday, don't
21 -- you should not disclose the content of that
22 discussion.

23 THE DEPONENT: Okay.

24 BY MS. GEIST:

1 Q. Doctor Alexander, just so you're clear, I
2 do not want to know what you discussed with
3 plaintiffs' counsel, whether that's Mr. Burnett or
4 anybody else from Motley Rice or the other law
5 firms representing the plaintiffs. I'm not
6 entitled to know about that and I'm not asking you
7 about that.

8 I am asking you about discussions that
9 you had with your colleagues at Monument Analytics
10 why you had those discussions without counsel to
11 prepare for your deposition, and what did you talk
12 about?

13 A. Yeah, they -- I'm sorry, I'm being
14 interrupted. Just one minute.

15 They were the same conversations,
16 essentially. In other words, they were all focused
17 on the same stuff, so I will look to you, again,
18 through a process of consensus, to instruct me how
19 I should proceed.

20 But there was no strong material
21 difference between the types of conversations or
22 the types of content in the conversations that I
23 had with my colleagues from Monument Analytics and
24 the content and conversations of the conversations

1 that I had yesterday.

2 They were part and parcel --

3 MR. BURNETT: So --

4 A. -- you know, the same content.

5 MR. BURNETT: So Doctor Alexander --

6 MS. GEIST: Just hold on, Mr. Burnett.
7 I'm not going to go down this road. If the witness
8 is telling me essentially that these are the same
9 conversations, I'm going to reserve my right for
10 the record to request his notes from these meetings
11 that he indicated were on his hard drive, meetings
12 with individuals at Monument Analytics to prepare
13 for the deposition.

14 And again, I'm limiting our right to
15 ask for those notes that reflect meetings where
16 counsel was not present.

17 MR. BURNETT: Right, and I -- given
18 that Doctor Alexander has said he can't
19 differentiate the subject matter of those meetings
20 between counsel and not counsel, I will instruct
21 him not to answer further and I think we should all
22 move on.

23 MS. GEIST: Yeah, well, that's why I
24 said to you, "I'm not going down this road."

1 I know the rules.

2 BY MS. GEIST:

3 Q. So Doctor Alexander, you also indicated to
4 me that you watched the Netflix documentary
5 Heroin(e); is that correct?

6 A. Yes, but may I make one comment prior,
7 please? Which is the notes that I have is a single
8 document. I don't have two sets of notes. I have
9 a one to two-page document that reflects, again,
10 the conversations that I've had with counsel and
11 the like.

12 So I just want to be clear for the
13 record that I don't have two parallel sets --

14 MR. BURNETT: Okay.

15 A. -- sets of notes.

16 MR. BURNETT: So Doctor Alexander, we
17 can get into the notes later.

18 THE DEPONENT: Okay, that's fine.

19 MR. BURNETT: We're moving on.

20 THE DEPONENT: Fair enough.

21 Q. I'm going to ask one follow-up question. I
22 just need to be clear. Doctor Alexander, do you
23 have notes that reflect your meetings with
24 individuals at Monument Analytics where counsel was

1 not present?

2 A. Again, I have one -- I'm not quite sure how
3 to answer because I have one -- you know, I have
4 one document that reflects the -- the aggregate of
5 my meetings and conversations with counsel and with
6 colleagues, and so in my mind, it's -- it's one
7 document.

8 Q. Understood. And again, we can revisit this
9 after the deposition, we reserve our right to
10 request those notes, and I understand counsel's
11 objection.

12 But we can deal with it after the
13 deposition.

14 That -- my question to you, I think,
15 that was not answered yet was: Why did you watch
16 the Netflix documentary Heroin(e)?

17 A. Well, I rewatched it, and I did so because
18 it is -- because I recalled from the first time
19 that I watched it that it's a -- you know, it's a
20 -- it's one compelling window through which to
21 understand the way that the opioid epidemic has --
22 has ripped this rural Appalachian community apart,
23 and so I felt that it would be helpful to have that
24 top of mind as I -- as I have conversation and --

1 with you.

2 Q. Doctor Alexander, I think you indicated
3 earlier you spent 75 hours total for your time on
4 this particular case. Is your -- is your billing
5 rate \$900 an hour?

6 A. Yes, it is.

7 Q. So you expect to be paid - if you haven't
8 been compensated yet - 900 times 75? Is that
9 right?

10 A. Well, I'm not -- I'm not paid -- I mean,
11 that payment goes to Monument Analytics. That
12 payment doesn't come directly to me.

13 Q. Understood. In terms of additional work,
14 sitting here today, do you plan on doing any
15 additional work in this case in preparation for
16 trial?

17 A. I mean, I will do whatever I'm asked to do
18 by plaintiffs that is consistent with what I can do
19 and what I can offer. So I'm sorry that I don't
20 have a direct answer for you, but the bottom line
21 is: I'm here to serve the courts and to serve the
22 community and if I'm asked to do more work, if it
23 fits in with my family and my professional needs
24 and my work/life balance, I'm happy to take that

1 on.

2 Q. I guess -- let me ask my question
3 differently. As of this day, this point in time,
4 do you have any additional work on your plate now,
5 any action items that you need to address before
6 trial?

7 MR. BURNETT: And Doctor Alexander,
8 when you answer, you know, answer only to the
9 extent that would not disclose, you know,
10 communications with counsel or trial strategy or
11 anything like that.

12 A. I do not. The answer to your question,
13 Ms. Geist, is that I do not.

14 Q. Thank you. And you can put Exhibit 1 to
15 the side for now, Doctor Alexander. Thank you.

16 A. Will -- may I ask, just a point of order,
17 will these be shredded or should I organize them
18 sort of neatly in some fashion?

19 Q. You can -- you can toss it on the floor.
20 Or you could put them in a neat pile for -- for
21 Mr. Burnett. I think we have an official copy
22 given the Zoom deposition, which makes things
23 actually kind of easy.

24 MR. BURNETT: Although, I would say

1 it's possible that we'll go back to exhibits, so
2 you probably want to leave them in a stacked pile
3 so that you can refer back during the deposition as
4 needed.

5 THE DEPONENT: Okay, thank you.

6 Q. Did you review your prior deposition
7 transcript to prepare for today? And when I say
8 "prior deposition transcript," I'm talking about
9 the only other time you provided expert testimony
10 on behalf of plaintiffs in the opioids litigation
11 in the MDL Ohio case?

12 A. No, I did not.

13 Q. Doctor Alexander, you can go ahead and open
14 up what we have marked as Tab 2 or Exhibit 2, and
15 this will be Exhibit 2 to your deposition.

16 VIDEO TECH: Exhibit 2 has been
17 introduced on Exhibit Share.

18 ALEXANDER DEPOSITION EXHIBIT NO. 2

19 (Deposition transcript of G. Caleb
20 Alexander, USDC, Northern District of
21 Ohio, MDL No. 2803 dated 4-26-19 was
22 marked for identification purposes as
23 Alexander Deposition Exhibit No. 2.)

24 A. Okay, I have it in front of me.

1 Q. Great. And just for the record, Doctor
2 Alexander, this is the transcript from the
3 deposition that you provided in the In
4 Re: National Prescription Opiate Litigation
5 pending in the Northern District of Ohio, and that
6 deposition was provided on April 26, 2019.

7 Is this familiar to you, Doctor
8 Alexander, this document, this transcript?

9 A. I've -- yes, I've seen it before. Again, I
10 did not look at it recently, so it's been, you
11 know, six months, nine months, twelve months since
12 I've looked at it.

13 But yes, I do -- I have seen this
14 before.

15 Q. Okay. And during this deposition, were you
16 under oath and you swore to tell the truth?

17 A. Of course, yes.

18 Q. And I assume you did that?

19 A. Of course, yes.

20 Q. Now, did you have an opportunity to review
21 - what we call a read and sign - of your deposition
22 transcript after the deposition was concluded?

23 A. Yes, I did.

24 Q. Okay. So you looked through it, you made

1 sure it was free from error and then you signed off
2 on it. Is that a fair summary?

3 A. Yes.

4 Q. Okay. This is not relevant really to you,
5 Doctor Alexander, but the parties in the case
6 received instruction from the Court who is
7 presiding over the West Virginia matter brought by
8 Cabell County/City of Huntington that we are not to
9 engage in what would be considered duplicative
10 testimony.

11 So in other words, we have received
12 instruction from the Court that we are not to,
13 essentially, ask you the same questions that have
14 been asked in the past.

15 So my question to you is: May I rely
16 on your -- your responses and answers in this
17 deposition transcript that we've marked as Exhibit
18 2 as truthful and accurate to the best of your
19 ability in the case?

20 A. Well, only -- only at that time. I mean,
21 this -- the deposition, it takes place at a moment
22 in time, and I -- in my report, I make it clear
23 that I reserve my right to update my opinions based
24 on new information that I may have.

1 So it could well be the case that
2 there are questions that I was asked then that I
3 answered one way that if asked again, I would
4 answer another.

5 But in all cases, I'll answer to the
6 best of my ability and I'll answer truthfully and
7 I'll answer as a practicing internist and
8 epidemiologist and public health expert.

9 Q. Now, this deposition that you provided in
10 the Ohio case was about a year and a half ago,
11 April 26, 2019. Is that right?

12 A. Yes, ma'am.

13 Q. And if you look with me, Doctor Alexander,
14 at some of what I will call general questions -- I
15 just want to give you a sense of what I'm referring
16 to. Starting on page 24 and going through really
17 page 36, these appear to me to be general questions
18 relating to your views as a physician regarding the
19 treatment of chronic pain with opioids and the
20 obligations of a physician with respect to
21 prescription medications.

22 Do you want to just flip through pages
23 24 to 36 for me briefly and just let me know if I
24 can rely on the testimony that you provided about a

1 year and a half ago in the MDL case?

2 A. Well, I'm -- I'm happy to look at the
3 pages, but unless I spend a -- so I'm happy to do
4 so, but unless I spend a significant amount of time
5 -- I mean, I -- I will want to look carefully at
6 each question if indeed we're trying to confirm
7 that my views on any given question haven't
8 changed.

9 But let me -- just give me a minute,
10 please, and let me see whether I can give you some
11 sort of global sense that my feelings are the same
12 and my answers would be the same.

13 So --

14 Q. Let me -- Doctor Alexander, let me
15 interrupt you for one minute. I don't want to
16 waste time, because we have a lot to get through
17 today.

18 A. Okay.

19 Q. So let me ask it this way --

20 A. Okay.

21 Q. -- on April 26, 2019 when you provided this
22 deposition, you did so truthfully and you were
23 under oath, and at that moment in time, you were
24 providing answers accurately, truthfully to the

1 best of your ability on that date. Correct?

2 A. Absolutely.

3 Q. Okay. So I am going to set this aside,
4 because I am cognizant of the judge's ruling, so I
5 don't want to go through the same questions with
6 you again today, because I think that's contrary to
7 the -- to the order.

8 A. Okay.

9 MR. BURNETT: Counsel, let me just
10 interject also that you asked him to look at
11 questions starting at page 24. 24, line 10 to 12,
12 makes exclusive reference to some accounting in
13 Cuyahoga County, so that's consistent with what he
14 said, which is that, you know, it would depend on
15 that point in time and it would depend on the
16 content.

17 So you can't ask him whether questions
18 that were about Ohio would apply equally to West
19 Virginia.

20 MS. GEIST: Well, all right.

21 Q. So with that instruction, Counsel -- Doctor
22 Alexander, let's take a look at this transcript.

23 A. Okay.

24 Q. Beginning on twenty -- page 24, there's

1 some general questions relating to your agreement
2 that chronic pain is a serious medical condition.
3 That's the first question. And then there are some
4 questions that are general and then there are some
5 questions that are specific to Summit County/
6 Cuyahoga County, Ohio. So --

7 A. I'm sorry to interrupt. One question. So
8 I see four small pages on the piece of paper, but
9 then the piece of paper has a separate page.

10 So when you say "page 24," are you
11 referring to at the bottom of the document, page
12 24, or are you referring to one of those four
13 quadrants where there's four pages on a given piece
14 of paper?

15 Q. One of the four quadrants.

16 A. Okay. So page 24 begins - just to be
17 clear; perhaps it could be displayed - with "Yes, I
18 am." Is that correct? "So let's see if there are
19 some things we can actually agree on."

20 Q. That is correct. This is what we call a
21 mini script --

22 A. Okay.

23 Q. -- it's more green and environmentally
24 better --

1 A. Gotcha.

2 Q. -- to not have so many pages. So page 24,
3 Doctor Alexander, on April 26, 2019, you were
4 asked, "Do you agree that chronic pain affects
5 people in Summit County, Ohio and Cuyahoga County,
6 Ohio" at Line 10 through 12, and you answered, "I
7 do."

8 Do you see that?

9 A. Yes, I do.

10 Q. Okay. Do you agree that chronic pain
11 affects people in Cabell County and in the City of
12 Huntington?

13 A. Yes, I do.

14 Q. For now, you can put the transcript aside,
15 Doctor Alexander. We might have to go back to it.

16 A. Of course, of course.

17 Q. So if you could just put it aside. Thank
18 you.

19 A. Yeah.

20 Q. Why don't we now, Doctor Alexander, take a
21 look at your expert report and some of the
22 accompanying attachments that you provided with
23 your report?

24 So you can open up Envelope 4.

1 A. Okay.

2 Q. And then I might go ahead -- while you're
3 getting that envelope out of the box, Doctor
4 Alexander, and take out 5, Tab 5 or Exhibit 5, and
5 then Tab 7 or Exhibit 7.

6 MR. BURNETT: They're all tabs, not
7 exhibits.

8 MS. GEIST: Yeah, well, sorry.
9 They're going to be marked as exhibits according to
10 the tab numbers.

11 MR. BURNETT: Oh, okay.

12 VIDEO TECH: Exhibits -- Tabs 4, 5 and
13 7 have been marked as Exhibits 4, 5 and 7?

14 MS. GEIST: Thank you, John.

15 ALEXANDER DEPOSITION EXHIBIT NOS. 4, 5 and 7
16 ("Abatement Plan for Addressing the
17 Opioid Crisis in Cabell County and the
18 City of Huntington," Expert Report of
19 G. Caleb Alexander, MD, MS dated
20 8-3-20; Expert Witness Report of G.
21 Caleb Alexander, MD, MS, Appendix A -
22 Johns Hopkins Report: "From Evidence
23 to Impact" and Expert Witness Report
24 of G. Caleb Alexander, MD, MS,

1 Appendix C - List of sources that were
2 consulted was marked for
3 identification purposes as Alexander
4 Deposition Exhibit Nos. 4,-- 5 and 7.)

5 A. Okay, I have those available.

6 Q. Okay. Great. Let's go ahead, Doctor
7 Alexander, and take a look at Exhibit 4, which is
8 entitled "Abatement Plan for Addressing the Opioid
9 Crisis in Cabell County and the City of Huntington"
10 dated August 3rd, 2020, for the record.

11 And can you just identify this, Doctor
12 Alexander, as your expert report in the case?

13 A. Yes, it is my expert report.

14 Q. Okay. And do you need to make any changes,
15 revisions or updates to this expert report?

16 A. No, but thank you for the question -- or
17 opportunity. But I do not.

18 Q. And does this expert report provide a
19 complete list of all of the opinions you intend to
20 offer on behalf of plaintiffs in this case?

21 A. Yes, it does. I mean, barring something
22 that there was agreement -- again, I will follow
23 the instructions of the judge and of the Court. So
24 if I were asked to do something by the judge, I'm

1 happy to try to be of service any way that I can.

2 But -- but this report is otherwise
3 complete.

4 MR. BURNETT: And I will note that the
5 report contains a number of appendices and
6 materials considered, which were served on counsel
7 that are not included within this 125 page
8 document.

9 MS. GEIST: Yep. No, I'm going to get
10 to that. Thank you.

11 Q. But in other words, Doctor Alexander, if
12 counsel for the defendants in this case would like
13 to know, what is Doctor Alexander going to testify
14 about, what opinions are you going to offer in the
15 case, we will be able to find them here in this
16 report and in the attachments to the report. Is
17 that fair?

18 A. Yes, it is. Again, reserving any requests
19 that the judge may make of me or that parties may
20 agree to otherwise, this report and the materials
21 that Mr. Burnett mentioned that accompany it
22 represent the totality of my opinions in the case.

23 Q. Now, I noticed, Doctor Alexander, if you
24 look at page 3 of your report, the first paragraph,

1 sort of in the middle of that paragraph, you write,
2 "I have been asked to discuss ways to abate or
3 reduce the harms caused by the oversupply of
4 opioids into the Community," and "the Community"
5 refers to Cabell County/City of Huntington; is that
6 correct?

7 A. Yes, ma'am.

8 Q. Do you intend to offer any opinions in this
9 case regarding causation? In other words, who or
10 what caused or contributed to the opioid epidemic
11 in Cabell County/Huntington.

12 A. I was not asked to focus on lines of
13 causation, no.

14 I was asked to focus on evidence-based
15 solutions to abate the opioid epidemic.

16 Q. So you don't have any opinions in the case,
17 and at trial you don't intend to say to the judge,
18 "Well, in my opinion, I think that there were
19 certain parties who caused or contributed" and list
20 them out. You will not do that, correct?

21 MR. BURNETT: Objection.

22 A. Well, I mean, indirectly, I suppose. I
23 mean, if you consider a community that had, I
24 believe - what - 40 million prescriptions for

1 opioids in a given year that were enough to supply
2 every adult with 400 tablets, I mean, implicitly,
3 when I design an abatement program, there is
4 implicitly some notion about what caused the
5 epidemic.

6 Otherwise, I wouldn't have, as part of
7 my abatement plan, interventions targeting the
8 oversupply of opioids, for example.

9 So I suppose that -- that, again,
10 implicitly there's some discussion about cause, and
11 I would also say that if the judge asks me a
12 question, I'm not going to decline to answer it.

13 But with that being said, my report is
14 not about how we got here; it's about where we go
15 going forward.

16 Q. And that is how I read your report as well.
17 So I'm going to ask you a follow-up question or
18 two. You do not have a sentence in your report
19 that identifies who or what contributed or caused
20 what you refer to as an oversupply of opioids into
21 the Cabell County/Huntington community.

22 MR. BURNETT: Counsel, I'm going to
23 object on two grounds. First of all, his report
24 does refer to oversupply, not just in Paragraph 1.

1 And number 2, it's not fair to ask him
2 in a 125 page line document if he refers to a
3 specific point in a specific sentence.

4 You know, we can review the whole tran
5 -- the whole report if we need to to confirm that,
6 but I object.

7 BY MS. GEIST:

8 Q. Can you answer my question, Doctor
9 Alexander?

10 A. Well actually, my reply was going to be not
11 dissimilar from Mr. Burnett's second point, which
12 is that this is a long report and it discusses
13 many, many different matters, and so if you ask
14 your question again, I'll try.

15 But if the question is about whether
16 my report has other -- whether elsewhere in my
17 report I discuss the genesis of the opioid
18 epidemic, the answer is, I believe that I do in
19 many places, and I'd be happy to review those
20 statements with you and we could discuss them and
21 the evidentiary basis for them if that's helpful to
22 do so.

23 Q. Let me ask it -- ask it this way: In your
24 deposition in the MDL in Ohio, you were asked

1 whether you were going to provide opinions, expert
2 opinions, to a reasonable degree of medical
3 professional certainty as to causation, meaning who
4 caused or contributed to the oversupply of opioids
5 from your perspective.

6 And your answer there was you were not
7 going to do that. Do you recall that?

8 A. Well, I don't recall my specific answer,
9 but I wouldn't be surprised if I said "No,"
10 although I may well also have said - and I'm sure
11 that I said somewhere in my deposition - that I
12 will speak to whatever matters I am requested to
13 speak to where there's agreement that I should do
14 so or where the judge requests it.

15 So I certainly kind of caveat out that
16 I'm here to serve and that I'm here to provide my
17 best expertise as a practicing internist and as an
18 epidemiologist.

19 And again, you know, my report isn't
20 focused on looking backwards; it's focused on
21 looking forwards. But I think you have to have
22 some sense of where we've been if you are designing
23 a plan for where we want to go.

24 Q. And I understand that, Doctor. But some

1 sense of where we've been is not the same as
2 offering an opinion as an expert to a reasonable
3 degree of medical or professional certainty as to
4 the causes or contributing factors to the opioids
5 epidemic in Cabell County/Huntington.

6 Do you understand that?

7 A. I mean, I do. But I think there's a bit of
8 nuance as well. My report is not focused -- I'm
9 sorry if I was speaking too quickly.

10 I do understand that. I do think
11 there's a bit of nuance here. But my report does
12 not focus on causation, and it's not where I spend
13 my time.

14 But again, there are many places in my
15 report where I discuss evidence or discuss
16 solutions that inherently are informed by an
17 understanding of the nature of the problem.

18 So for example, stigma. You know, I
19 don't discuss - and sort of try to quantify - the
20 role that stigma has played. But if you're going
21 to design a successful abatement program, you have
22 to consider the role that stigma has played.

23 And so I think of something like
24 opioid oversupply in that instance, or in that

1 sense. Cabell County and the City of Huntington
2 have been off the charts with respect to the volume
3 of opioids that were -- flooded the community.

4 And they still, frankly, are high
5 above the national average. And I think any
6 sensible abatement plan has to be informed by
7 knowledge about opioid oversupply and the way that
8 that has driven and fed the epidemic.

9 Q. So let me -- let me ask it again, Doctor
10 Alexander, because this might change how much time
11 we spend here together.

12 A. Okay.

13 Q. In the MDL, in Ohio, your testimony was,
14 well, all of this underlies your research -- your
15 expert report is focused on -- is focused on
16 forward-looking interventions and programs. Do you
17 recall that?

18 A. Yes, I do.

19 Q. And you are not going to be offering expert
20 opinions to a reasonable degree of medical
21 professional certainty as to cause or causes with
22 respect to the opioid epidemic. Do you recall that
23 testimony?

24 A. Again, I don't recall my precise responses

1 in deposition, but it sounds consistent with what I
2 understood at the time my role to be.

3 Q. Okay.

4 MR. BURNETT: And Counsel, let me just
5 interject here. You're talking about a deposition
6 that occurred, you know, 15 months ago. We have
7 not reviewed the transcript; you're not referring
8 to any specific page of the transcript; and he said
9 that he has not reviewed it in six to twelve
10 months.

11 So I don't think it's fair to ask him
12 his answers to specific questions in the 2019
13 deposition.

14 MS. GEIST: So can we keep our
15 objections to form, Counsel? Because you know
16 that's the rule and not the speaking objections
17 that you're doing now.

18 Q. So Doctor Alexander, in -- you just spoke
19 about your role in that case. Do you see your role
20 in this case as an expert witness for the
21 plaintiffs in Cabell County/City of Huntington to
22 be any different than your role in the Ohio case?

23 MR. BURNETT: Objection.

24 A. I believe my general role is very -- is --

1 is similar. I believe my general role is similar,
2 which is to advise the courts and the communities
3 regarding evidence-based approaches that can be
4 used to prevent further harm from occurring.

5 Q. And if we look at the first paragraph here
6 in your report, you outline what you have been
7 asked to do in this case. Is that right?

8 A. Yes, ma'am.

9 Q. Okay. And just to recap, would you agree
10 with me that what you've been asked to do as an
11 expert witness on behalf of the plaintiffs in this
12 case is to, one, "discuss ways to abate" - using
13 your word - "or reduce the harms caused by the
14 oversupply of opioids into the Community;" two,
15 "estimate the size of specific populations that may
16 require interventions" "over a 15-year time
17 period;" and then three, "provide recommended cost
18 estimates for certain interventions."

19 Does that appropriately outline what
20 you have been asked to do here on behalf of
21 plaintiffs?

22 A. It does. And in doing so, I have reviewed
23 an enormous volume of evidence, and -- and
24 undertaking these goals requires consideration of

1 many other -- many other factors and facets. So we
2 can sort of peel back layers of the onion together.
3 But at the highest level, yes, I think that this
4 paragraph summarizes well what I was asked to do by
5 plaintiffs.

6 Q. Okay. And you have not been asked by
7 plaintiffs to provide expert testimony to a
8 reasonable degree of medical certainty or
9 probability as to the causes of what you say was an
10 oversupply of opioids into Cabell County/
11 Huntington.

12 That was not part of what you were
13 asked to do; is that correct?

14 MR. BURNETT: Objection, asked and
15 answered.

16 A. Yeah, I think we've discussed that before,
17 you know, the focus of my work is looking forwards;
18 but again, I think that in order to design an
19 evidence-based abatement program, one has to
20 understand the nature of the problem.

21 And so that requires some evaluation
22 of the historical context and the foundation that
23 -- that -- that the current situation rests upon.

24 Q. So again, I feel like we're going around

1 and around and around, Doctor Alexander, so I'm
2 going to try it one more time. At the trial in
3 this case, do you intend to go beyond opinions that
4 you have stated here: Opinions relating to ways to
5 abate or reduce the harms, how to estimate the size
6 of the populations that may require interventions
7 and what would be the cost estimates for some of
8 those interventions?

9 Are you telling me you're going to go
10 beyond some of those opinions at the trial?

11 MR. BURNETT: Objection.

12 A. I wouldn't go beyond them unless the judge
13 asked, but in addressing or staying within bounds
14 of these opinions, invariably there are -- there
15 are elements of this that require understanding the
16 nature of the problem.

17 So briefly, if you consider an
18 intervention such as physician or prescriber
19 education or education of the general public or
20 interventions to, you know, distribute naloxone,
21 any of these is predicated upon some understanding
22 of the nature of the problem.

23 And as an epidemiologist, that's what
24 I'm trained to do. So I think it's fair to say

1 that at the highest level, that I was asked to
2 focus on these areas and that's where I plan to
3 offer opinions.

4 But if a judge asked me or if counsel
5 agrees and I'm asked a question such as, "Well, why
6 do you think naloxone is important" or "Why do you
7 think that -- you know, why do you plan -- why does
8 your plan include services for children in foster
9 care whose parents have died of overdoses," then I
10 will -- I will discuss that.

11 And that may require, you know, moving
12 to root causes. Consider something like take-back
13 programs. You know, if I was asked, "Well, Doctor
14 Alexander, what's the role of a take-back program,"
15 it would require my discussing the fact that there
16 are, you know, tons of opioids sitting on
17 individuals' bedroom nightstands and in their
18 bathroom cabinets and that these should be disposed
19 of.

20 So -- so I -- I hope that that's
21 helpful. I'm trying to be helpful and to address
22 your question and your needs, but also want to just
23 emphasize my report includes, you know, 650
24 references or something and there's a lot of

1 science there that -- and some of it touches upon
2 causation and serves as the foundation for what I
3 propose for abatement.

4 Q. Sure. And I understand that some of your
5 references touch on causation, and I understand
6 your statement that your opinions are -- are
7 predicated - to use your words - on a -- on the
8 underlying nature and understanding of the problem.

9 But my issue here, Doctor Alexander,
10 is: This is the only chance we get to depose you.
11 We get to explore the opinions you intend to offer
12 at trial, and this report is supposed to provide us
13 with notice: What are you going to say at trial?

14 And so I don't see any section in your
15 report -- and I would note it's a very long report.
16 But I don't see any section in your report where
17 you say, "As an epidemiologist" or "As a health
18 care provider, I have done extensive review into
19 the cause or causes or contributions to the opioid
20 epidemic and I have considered all of the following
21 and I have reached the conclusion that this or
22 these -- for these particular people or individuals
23 or groups are causes of the epidemic."

24 That is not anywhere in your report,

1 correct?

2 MR. BURNETT: Counsel, I'm going to
3 object again. That's a -- that's an unfair
4 question. Again, you're asking him the question
5 about the entirety of his report. If you want to
6 go off the record, we can talk about this further,
7 but you're asking him whether the entirety of his
8 opinions are contained in the first paragraph of
9 what is 125-page-long report.

10 MS. GEIST: So --

11 MR. BURNETT: I think the report
12 speaks for itself.

13 BY MS. GEIST:

14 Q. Can you -- can you direct me, Doctor
15 Alexander, to any place in your report - and you
16 can take all the time you want - where you go
17 through the analysis and you discuss and reach
18 conclusions about the causes or the contributing
19 factors to the opioid -- to the oversupply of
20 opioids into the community, to use your words?

21 MR. BURNETT: Objection.

22 A. Yeah, there's -- I think I've answered
23 this. But there are many statements in my report
24 that -- that have some -- that have to do with

1 understanding the nature of the problem, and
2 inherently, that -- that's partly an effort at
3 understanding what caused the problem. That's the
4 nature of epidemiology, and pharmacoepidemiology.

5 But you also asked another question,
6 and I would say that although I know Mr. Burnett
7 objected -- but there's no -- there's no specific
8 section of my report that is focused exclusively on
9 arguing lines of causation, if that helps to
10 address your query about whether there's a section
11 of my report that's devoted exclusively to trying
12 to apportion responsibility across different groups
13 or drivers or what have you.

14 There's no section like that in my
15 report.

16 Q. Okay. And you said to me you needed to
17 understand the nature of the problem and understand
18 the cause. But would you agree with me that
19 understanding cause or the nature of the problem -
20 using your words - is different from being asked to
21 offer an expert opinion to a reasonable degree of
22 medical or scientific certainty as to the causes of
23 the oversupply of opioids into Cabell County/
24 Huntington, to use your words?

1 MR. BURNETT: Objection, asked and
2 answered.

3 Again, his opinions are contained in
4 the report.

5 MS. GEIST: Those are two different
6 things we're talking about.

7 Q. Is that fair, Doctor Alexander?
8 Understanding the nature of a problem and
9 understanding the causes is different than being
10 asked to provide an expert opinion. Do you
11 understand that?

12 A. Well, it -- it sounds to me like the first
13 is sort of a scientific or epidemiologic exercise,
14 and the second is rendering some legal opinion or
15 judgment, and I would prefer to let counsel work
16 this out.

17 I mean, I've tried to be helpful in
18 identifying where I go. I was not asked, first and
19 foremost, to argue or delineate lines of causation.
20 It's -- again, my focus is looking forward.

21 But I think in order to look forward,
22 you have to understand what's behind you, and I
23 gave some examples where I think it's very
24 important to understand the nature of the epidemic,

1 and in particular, we could talk about the
2 oversupply of prescription opioids when designing
3 abatement solutions.

4 Q. Understood. And again, just following up
5 on what you just said, you were not asked to look
6 at lines of causation. You were asked to design
7 programs and interventions looking forward.
8 Correct?

9 A. Yes. And in order to do so, one has to
10 understand the genesis of the epidemic.

11 Q. Understood. Okay.

12 MR. BURNETT: Counsel, we've been
13 going an hour and a quarter. Just putting it out
14 there.

15 MS. GEIST: Yeah, we can -- we can
16 take a break.

17 Q. Would you like to take a break, Doctor
18 Alexander?

19 A. Sure. Shall we reconvene at, say, five
20 minutes to the hour? That would be about ten
21 minutes.

22 VIDEO OPERATOR: The time is 10:46.
23 We are now going off the record.

24 (A recess was taken after which the

1 proceedings continued as follows:)

2 VIDEO OPERATOR: The time is 10:57.

3 We are now back on the record.

4 BY MS. GEIST:

5 Q. Doctor Alexander, again do you have your
6 report in front of you?

7 A. Yes, ma'am, I do.

8 Q. On page 8 of your 125-page report, at
9 Paragraph 17, if you could go there with me,
10 please.

11 A. Yes, ma'am.

12 Q. Here you state that "I conclude an opioid
13 epidemic currently exists within the Community."
14 And again, for the record, every time we refer to
15 "the community" in this deposition or in your
16 report, that refers to Cabell County/City of
17 Huntington, correct?

18 A. Yes, ma'am.

19 Q. Okay. So you have concluded that an opioid
20 epidemic currently exists within Cabell County/
21 Huntington?

22 A. Yes.

23 Q. You are aware, though, that a recent study
24 has shown a nearly 40 percent decrease in the

1 overall opioid prescription rates and a 60 percent
2 decrease in the quantity of opioids prescribed per
3 visit to a physician and a reduction in the
4 strength of opioids prescribed following a public
5 and provider education campaign.

6 You're aware of all that?

7 MR. BURNETT: Objection.

8 A. I'm aware that there have been reductions
9 in opioid prescribing, yes, but I'm not -- I can't
10 confirm the precise data points without reviewing
11 the sources of information.

12 But yes, I am aware that there have
13 been reductions in -- fortunately, that there have
14 been some reductions in the volume of opioids into
15 the community over the past few years.

16 Q. In connection with your research and review
17 of the materials in this case, did you look at the
18 latest data from the Department of Health and Human
19 Services in West Virginia providing preliminary
20 data on 2018 drug overdoses?

21 MR. BURNETT: Objection.

22 A. Yeah, I would want to look at any given
23 document again.

24 Again, there were, I believe, more

1 than 650 references in my report, and that doesn't
2 include all of the additional materials that are
3 sourced elsewhere either in the redress models or
4 materials that I reviewed and considered and didn't
5 ultimately cite.

6 So I'm not able to confirm having seen
7 or incorporated a given document without reviewing
8 that with you at this time.

9 Q. Now, you do cite in your own report,
10 though, that study that I just referred you to.
11 That's at page 16 of your report, if you want to go
12 ahead there and look.

13 A. And which reference are you referring to?

14 Q. At Paragraph 38, Doctor.

15 A. Okay. And where in the paragraph?

16 Q. It's -- it's about four or five lines down.
17 Here you note a recent quality improvement study
18 looking at the overall decrease in opioid
19 prescription rate and the decrease in quantity of
20 opioids prescribed per visit?

21 A. That's at a regional health system in
22 Maryland?

23 Q. Is that reflective of the national decrease
24 in opioid prescription and the national decrease in

1 the quantity of opioids prescribed per visit by
2 physicians?

3 A. Well, this is a reference to a single
4 quality improvement study. So I -- I think it
5 would -- it would require some caution in inferring
6 something about national trends in opioid
7 prescribing based on a single study of a regional
8 health system in Maryland.

9 Q. Well, let's just -- let's focus on Cabell
10 County/Huntington's since that is the case that
11 we're talking about today.

12 A. Okay.

13 Q. Are you aware based on the West Virginia
14 Department of Health and Human Services data that
15 specifically in Cabell County, there has been an
16 overall decline of 22 to 26 percent in opioid-
17 related overdoses {sic} from 2017 to 2018?

18 Are you aware of that?

19 MR. BURNETT: Objection.

20 A. Again -- I'm sorry, can you ask the
21 question again, please?

22 Q. Sure. Are you aware of the data from the
23 West Virginia Department of Health and Human
24 Resources reporting specifically - based on

1 preliminary data - that there has been a 22 to 26
2 percent overall decline in opioid-related deaths
3 from 2017 to 2018?

4 MR. BURNETT: Objection.

5 A. Yeah, so I believe this is a year-over-year
6 analysis of preliminary data, and I believe there
7 have been declines noted. And that's quite
8 fortunate, because as you know -- you know, the
9 rates of overdose and other opioid-related
10 morbidity and mortality in Cabell County and the
11 City of Huntington have been off the charts.

12 And, I mean, it's not by accident that
13 it's been dubbed the overdose capital of the world.

14 So I'm aware of some modest gains, and
15 I think these are most important, and most
16 important for the community itself and to put some
17 wind in the sails, but I think we have an
18 enormously long way to go, and I would have grave
19 concern about, you know, overinterpreting some --
20 some -- some glimmers of hope as evidence that
21 somehow there's no longer an opioid epidemic within
22 the community.

23 I think nothing could be further from
24 the truth.

1 Q. Oh, when you say "opioid epidemic," would
2 you agree with me that at least as reported by the
3 West Virginia Department of Health and Human
4 Services, the current opioid epidemic, if there is
5 one, relates to illicit opioids such as fentanyl,
6 heroin, carfentanil?

7 Do you agree with me on that?

8 MR. BURNETT: Objection.

9 A. No, I -- I mean, the -- and any -- the
10 situation on the ground at any given point in time
11 is a reflection of exposure that's happened over
12 years, and we know that -- that, you know, using a
13 measure like the volume of opioids prescribed at
14 one point in time to understand whether or not the
15 house is on fire is simply not a -- not a good
16 move.

17 In other words, the -- the
18 manifestations of overprescribing that happened in
19 -- at Time A can manifest for years, and indeed
20 generations.

21 So while I think that the measures of
22 opioid volume that you describe, reductions in
23 opioid volume, are welcome, I believe that West
24 Virginia is still much, much higher than national

1 averages.

2 I believe many people are still
3 receiving opioids that would do better with
4 alternative treatments, and you know, it's -- it's,
5 in part -- a lot of the morbidity is driven by
6 addiction and opioid use disorder, and that's a
7 chronic disease. It's a lifelong disease.

8 You know, people can be treated and
9 many people live happy, successful lives in
10 recovery, so it's highly treatable, but it's a
11 chronic disease, and so I just have a little bit of
12 concern about using, you know, day-to-day or sort
13 of year-to-year fluctuations in opioid prescribing
14 as some global measure of whether or not an
15 epidemic is taking place.

16 Q. You do disagree with the data from the West
17 Virginia Department of Health and Human Services
18 that indicates that in 2018, 82 percent of overdose
19 deaths were attributed to illicit opioids, not
20 prescription opioids?

21 MR. BURNETT: Objection. Is there a
22 specific document you would like to refer the
23 witness to?

24 MS. GEIST: I'm going to ask him the

1 question first.

2 A. I would like to see --

3 Q. That is -- that's the data from the
4 Department of Health and Human Services in West
5 Virginia --

6 A. Right.

7 Q. -- would you have any reason to disagree
8 with that?

9 A. Well, I --

10 MR. BURNETT: Objection.

11 A. I would like to review any document that's
12 being referred to, but I didn't mean to suggest
13 that I disagree with a data point that's been put
14 out by the West Virginia Department of -- of Public
15 Health, or frankly, you know -- but I would like to
16 see the document.

17 But what I was registering some
18 concern about was a notion that this is an epidemic
19 -- that there's a fentanyl epidemic.

20 I would characterize it as an opioid
21 epidemic. Just as I have concern about
22 characterizing this as an epidemic of abuse, I
23 would characterize it as an epidemic of addiction.

24 So you know, we can discuss sort of

1 the relative contributions of different --
2 different substances or different opioids, but my
3 concern would be I wouldn't want to overlook the
4 important role that prescription opioids have and
5 continue to play in driving opioid-related
6 morbidity and mortality.

7 Q. And do you know from your research and
8 analysis how -- what percentage of the 2018
9 overdose deaths related to prescription opioids
10 only?

11 MR. BURNETT: Objection.

12 A. Yeah, I wasn't asked to -- I wasn't asked
13 to focus on that in my report.

14 Q. So you're not aware of -- when we're
15 talking about overdose deaths relating to opioids,
16 sitting here today, you're not aware of the latest
17 data and trends in West Virginia and Cabell County
18 specifically about what substances are driving
19 overdose deaths?

20 MR. BURNETT: Objection.

21 Q. Is that -- is that correct, Doctor
22 Alexander?

23 A. No, it's not correct. I carefully reviewed
24 all of the materials that were provided to me and

1 that I had access to, and that included up-to-date
2 recent data from local, State and Federal sources.

3 So I would not -- I would not want to
4 characterize otherwise.

5 Q. Now, you said -- you brought with you today
6 a copy of your report, correct?

7 A. Yes, ma'am.

8 Q. And you have footnotes, of course,
9 citations to authorities and references in that
10 report. True?

11 A. Yes, ma'am.

12 Q. Okay. The data that I'm referring to,
13 Doctor Alexander, if you look at page 11 of your
14 report, you write - as I -- as I stated earlier -
15 that "there are glimmers of hope, with preliminary
16 data suggesting a 22" to "26% decline in
17 opioid-overdose deaths between 2017 and 2018 in
18 Cabell County."

19 MR. BURNETT: Counsel, what paragraph
20 is that? I'm not seeing that.

21 MS. GEIST: That is page 11, Paragraph
22 29.

23 Q. And your citation for that, Doctor
24 Alexander, is the data released by the West

1 Virginia Department of Health and Human Services on
2 September 5th, 2019. So you -- you reviewed that
3 data, correct?

4 A. Yes, ma'am.

5 Q. You acknowledge that in your report. True?

6 A. Yes.

7 Q. And --

8 MR. BURNETT: Doctor Alexander, if you
9 need -- if you need time to look at the footnote,
10 don't -- don't be rushed in confirming what she's
11 asking you to confirm.

12 THE DEPONENT: Thank you.

13 Q. You cited -- you cited the data from the
14 West Virginia Department of Health and Human
15 Services in your report as we're looking at.
16 Correct, Doctor?

17 A. Yes, that's right.

18 Q. Okay. Do you recall -- I mean, this is
19 significant. We're talking about trends in opioid
20 and nonopioid drug overdoses in West Virginia.
21 This is a significant report from the Department of
22 Health and Human Services.

23 Would you agree with me on that, this
24 type of report is significant to the case?

1 MR. BURNETT: Objection.

2 A. There are -- there are dozens of reports
3 and publications that are significant to the case.
4 And I guess I would just highlight that as I note
5 here, just two sentences later, "for every glimmer
6 of hope, there are other signs that the epidemic is
7 as active as ever." You know --

8 Q. All right. So let me -- let me ask you
9 about that.

10 MR. BURNETT: Counsel -- Counsel, I
11 don't believe Doctor Alexander was finished with
12 his answer.

13 Q. I didn't mean to cut you off, Doctor
14 Alexander. Would you like to say something else?

15 A. Yes. Thank you. So my point is that --
16 that as I note just a few sentences later, "For
17 every glimmer of hope, there are other signs that
18 the epidemic is as active as ever, many barriers
19 persist."

20 I cite information that "Cabell County
21 EMS reported that the number of overdoses that they
22 responded to in May of 2020 was two to three times
23 higher than the prior" --

24 Q. Can I stop you there -- can I stop you

1 there? I don't want to interrupt -- but whether
2 you just --

3 MR. BURNETT: Counsel, Counsel,
4 really, you have to let him finish his answer.

5 MS. GEIST: Well, this is going to be
6 a long deposition if Doctor Alexander is going to
7 read to me paragraphs from his report.

8 MR. BURNETT: You're asking him to
9 read from his report also. You can't interrupt him
10 to -- to interrupt him to ask if you can interrupt
11 him.

12 A. I won't read a lot from my report, and I
13 certainly am all for trying to provide you the
14 information you need in as efficient a means as
15 possible.

16 But my point here is that I relied
17 upon dozens of important references and sources of
18 information for the information that I've provided,
19 and that for every glimmer of hope, there are other
20 signs that the epidemic is as active as ever within
21 the community.

22 Q. And one of the signs of the epidemic -- and
23 a few times you've referred addiction, correct?
24 The issue here of what we're really talking about

1 relates to addiction, correct?

2 A. Well, I note addiction in contrast to the
3 term "abuse" which I have concerns about because of
4 the ways that I think the epidemic has been
5 misconstrued as an epidemic of abuse, and I don't
6 believe that that's the case. I think it's an
7 epidemic of addiction.

8 Addiction isn't the only thing that's
9 important here. There are many people without
10 opioid use disorder that still have a -- that
11 engage in nonmedical use or have otherwise been
12 impacted by the epidemic.

13 I mean, consider -- consider children
14 who have been orphaned. So I don't want to suggest
15 it's addiction kind of front, center, 24/7, 365.
16 But I also think that addiction is a better frame,
17 a better lens through which to view the epidemic
18 than is the term "abuse."

19 Because abuse is a behavior and
20 addiction is a disease. And they require very,
21 very different interventions.

22 Q. And addiction being a disease, you have
23 some familiarity and awareness of addiction even
24 though you're not an addiction medical specialist.

1 Correct?

2 MR. BURNETT: Objection.

3 A. I -- as a practicing internist, I treat
4 patients that have addiction to opioids and alcohol
5 and tobacco and other substances, and so yes, I
6 have -- insofar as it's relevant to my report and
7 my opinions that I've offered, I do have an
8 understanding of addiction.

9 Q. Now -- and so then, you're aware, Doctor
10 Alexander, I assume, from your citation to the
11 Department of Health and Human Services -- I'm
12 sorry, Department of Health and Human Resources
13 data, that right now, people with addiction are
14 looking to move to methamphetamine as part of their
15 addiction. Is that right?

16 A. Are you --

17 MR. BURNETT: Objection. Again, if
18 there's a cite to a specific document, I would
19 suggest we refer to the document.

20 MS. GEIST: Well, I will pull it out,
21 but I'm referring to Doctor Alexander's citation
22 that we're looking at right here on the screen in
23 Paragraph 29 of Footnote 105, which is the West
24 Virginia Department of Health and Human Resources

1 data from overdose incidents in 2018.

2 Q. I'm just asking you generally, Doctor
3 Alexander: You're not disagreeing that there has
4 been a significant increase in overdose deaths
5 relating to methamphetamine in Cabell County/
6 Huntington from 2014 to 2018? That's what the data
7 tells us, correct?

8 MR. BURNETT: Objection. I'm not
9 seeing that in Paragraph 29.

10 MS. GEIST: I'm not referring to
11 Paragraph 29.

12 Q. Can you answer my question, Doctor
13 Alexander? Would you agree with me that from 2014
14 to 2018, that there has been a significant increase
15 in overdose deaths involving methamphetamine?

16 MR. BURNETT: Same objection.

17 A. It would be helpful to review any
18 particular reference together, but I believe that
19 it is the case that -- that overdoses of
20 methamphetamine have increased over the time frame
21 that you inquire about.

22 Q. A significant increase. Agree with me on
23 that?

24 MR. BURNETT: Objection.

1 Q. The percentages in the document that you
2 cite in your report go from 3 percent of overdose
3 deaths involving meth in 2014 to 36 percent of
4 overdose deaths involving meth in 2018.

5 You know that to be the case, don't
6 you, Doctor?

7 MR. BURNETT: Objection. Again,
8 Counsel, the numbers that you're referring are not
9 on the face of the report. If we want to look at
10 the exhibit, I suggest we do that.

11 It's not fair to ask him to confirm
12 specific numbers in a document that he doesn't have
13 in front of him.

14 Q. You cite that report from the Department of
15 Health and Human Resources in your expert report,
16 do you not, Doctor Alexander?

17 A. Along with 650 some others, yes, I do.

18 Q. Okay. And -- but in general, I assume in
19 your research and work in the case, you are well
20 aware of the significant increase of
21 methamphetamine-related overdose deaths in Cabell
22 County/Huntington.

23 MR. BURNETT: Objection.

24 Q. Is that fair?

1 MR. BURNETT: Objection, asked and
2 answered.

3 A. I believe there have been increases in
4 overdoses from methamphetamine in this community
5 and in other communities around the country, yes.

6 Q. Now, you mentioned earlier that you had
7 reviewed the Netflix Heroin(e) documentary.
8 Remember that?

9 A. Yes, ma'am.

10 Q. Okay. And one of the -- one of the women
11 highlighted in that documentary is Jan Rader. Do
12 you recall that?

13 A. Yes, I do.

14 Q. Okay. And do you -- did you read the
15 deposition that she provided in connection with
16 this case?

17 A. I don't recall having done so, no.

18 Q. Okay. If I represented to you that Jan
19 Rader testified that crystal meth is making a
20 comeback in Cabell County/Huntington and that there
21 are -- the current trends that are concerning the
22 community involve the influx of crystal meth and
23 that is eclipsing heroin and fentanyl, any reason
24 to disagree with her perspective?

1 MR. BURNETT: Objection. We don't
2 have the transcript in front of us.

3 Q. We can take a look at it, Doctor Alexander.
4 We'll pull it later. But if that's what Jan Rader
5 said, I assume you would agree with her
6 perspective, given that she's on the ground in
7 Cabell County/Huntington.

8 A. It would be helpful -- if I'm asked about
9 it and if we're going to look at the transcript, it
10 would be helpful to look while I'm answering --
11 before I answer. I don't know the context of the
12 questions that were asked. But I think in general
13 -- I think, you know, my report focuses on opioids
14 and abating opioid related harms. So --

15 But I'd be happy to look at her -- her
16 deposition and her testimony if that's helpful to
17 do so.

18 Q. I assume though, I mean, Doctor Alexander,
19 you don't reside and live in the Cabell County/
20 Huntington community; is that true?

21 A. That is true. I live in Baltimore,
22 Maryland.

23 Q. Okay. So -- and somebody like Jan Rader
24 who lives in the community, if from her perspective

1 the current issue relates to an uptick in crystal
2 meth, I assume you would defer to her as somebody
3 living there as to what the current issues are
4 facing the community.

5 MR. BURNETT: Objection.

6 Q. Is that fair?

7 MR. BURNETT: Objection. He said that
8 he can't speak to what she testified to without
9 looking at it.

10 MS. GEIST: I understood that.

11 Q. But if that's what she said, I assume that
12 you would not -- you would not think that you have
13 more information than somebody living in the
14 community. Is that right, Doctor?

15 MR. BURNETT: Objection.

16 A. I mean, this feels to me a bit of a false
17 dichotomy. I don't -- I don't -- I wouldn't be
18 surprised to know that there are individuals that
19 are using methamphetamine and that the community is
20 -- is being impacted by that.

21 But I don't think -- you know, I think
22 if I heard correctly, you said something to the
23 effect of "The issue is X rather than Y" and I --
24 it feels to me like a false dichotomy.

1 I don't know that anybody -- it would
2 -- it would -- in my professional experience - and
3 based on my training as an epidemiologist and as a
4 professor of epidemiology, having worked on the
5 opioid epidemic for many years in many different
6 facets of the epidemic, I don't have any hesitation
7 in -- in arguing that there's an opioid epidemic
8 taking place within Cabell County and the City of
9 Huntington.

10 So it's not clear to me that -- that
11 -- there may be individuals that use alcohol; there
12 may be individuals that smoke; there may be
13 individuals that use cocaine. I wasn't focused on
14 that. I was focused on -- on opioids.

15 But I think that polysubstance use is
16 a serious issue, and I discuss in my report -- I
17 discuss that in my report, and -- and call that
18 out.

19 So again, if you'd like --

20 Q. I'm sorry, go ahead.

21 A. Again, if you would like to review Jan
22 Rader's transcript together or a specific data
23 point on trends in methamphetamine use, I'm happy
24 to do so. But I don't think it diminishes from the

1 incredible toll that the community has taken and
2 continues to take from opioids.

3 Q. And you did not read Jan Rader's deposition
4 transcript in connection with forming your opinions
5 in the case or in preparation for your deposition.
6 Is that correct?

7 A. That's correct. I didn't read her
8 transcript. But I certainly have -- I'm familiar
9 with who she is, and I have reviewed other
10 materials in the case that I think are informed by
11 her expertise and her value to the community as a
12 -- as a community member.

13 Q. And in terms of what drugs the -- or
14 illicit substances that the community is currently
15 dealing with, you would defer - in your own words -
16 to her expertise. Is that correct?

17 MR. BURNETT: Objection.

18 A. No. I'm sorry, I -- did I say that I would
19 defer to her? I don't -- I mean, I don't think
20 that this is a matter of deference. I think -- I
21 mean, what -- can you ask the question again,
22 please?

23 Q. No, I'm going to move on to something else.
24 In terms of -- you've mentioned a few

1 times the opioid epidemic. Would you agree with me
2 that there -- if there is an opioid epidemic
3 currently in Cabell County/Huntington, it is not a
4 prescription opioid epidemic? Can we agree on --

5 MR. BURNETT: Objection, asked and
6 answered.

7 MS. GEIST: No, I didn't answer -- I
8 didn't ask that question before.

9 Q. Can we agree on that, Doctor Alexander,
10 that to the extent there is a current opioid
11 epidemic today in Cabell County/Huntington, can we
12 agree it is not a prescription opioid epidemic?

13 MR. BURNETT: Objection, asked and
14 answered.

15 A. Yeah, I don't -- I wouldn't -- I think
16 we've discussed this, and in considering, for
17 example, whether there is a fentanyl epidemic, I
18 believe earlier in our conversation we discussed
19 whether or not there was a current fentanyl
20 epidemic or something to that effect.

21 And the bottom line is that -- that
22 prescription opioids have played a very important
23 role in the genesis of the epidemic and that many
24 people who use intravenous opioids initiated with

1 prescription opioids, and my report doesn't require
2 disaggregating the relative contributions of
3 different types of opioids to overall
4 opioid-related morbidity and mortality.

5 If you look at the molecular structure
6 of OxyContin and compare it with the molecular
7 structure of heroin, they're virtually
8 indistinguishable and their effects on the brain
9 and the body are virtually indistinguishable, and
10 so it should come as no surprise when you have the
11 volume of opioids, prescription opioids, coming
12 into the market as has occurred in Cabell County
13 and the City of Huntington that -- that many
14 adverse outcomes are going to ensue, and that's
15 exactly what has taken place.

16 So certainly there are people that use
17 heroin and certainly there are people that use
18 fentanyl, and there are plenty of people that use
19 prescription opioids nonmedically or have addiction
20 to them. So I -- I prefer not to frame the opioid
21 epidemic as one of a particular substance.

22 I think fortunately, perhaps, there
23 are evidence-based treatments that work very, very
24 well whether or not one is using heroin or that

1 started with prescription opioids or whether one is
2 using prescription opioids alone. We have
3 evidence-based treatments, and we have many other
4 abatement interventions that have a terrific body
5 of evidence to support them.

6 So -- so I'm not sure that it is
7 necessary, nor was I asked to disaggregate or
8 design one abatement plan for people that were
9 still using prescription opioids nonmedically or
10 addicted to them and a second abatement plan for
11 people using heroin or illicit fentanyl.

12 Q. Right. Just to be clear, your abatement
13 plan, the interventions and the programs that
14 you're proposing here for the individuals living in
15 Cabell County/Huntington, those apply to all
16 individuals who may have opioid use disorder or
17 haven't -- or have not met the diagnostic criteria
18 for opioid use disorder.

19 Your programs apply to all of those
20 people whether or not they are users of illicit
21 opioids or prescription opioids. Is that correct?

22 MR. BURNETT: Objection.

23 A. Well, my abatement plan includes
24 interventions to conduct public education campaigns

1 about pain management; it includes workforce
2 preparation; it includes community resiliency; it
3 includes care for families, grief support. It
4 includes many things.

5 My point is, it includes -- my point
6 is, it includes many things beyond treatment for
7 addiction. But -- but those parts of my report
8 that are focused on treatment provide treatment for
9 the community of individuals with opioid use
10 disorder, and they do not disaggregate whether or
11 not the opioid use disorder arises from
12 prescription opioids or heroin that began with
13 prescription opioids, etc.

14 Q. Okay. So is that a long-winded way of
15 saying, yes, I'm correct, your proposed abatement,
16 intervention and programs do not depend on any
17 individual having used prescription opioids at any
18 point in time? Is that fair?

19 MR. BURNETT: I object to the
20 characterization of the witness' testimony as
21 long-winded.

22 A. And that --

23 Q. I feel like we're going to have a long day
24 here, Doctor Alexander, so I'm trying to cut

1 through some information. If you could focus on my
2 question without providing any narrative, I would
3 appreciate it.

4 MR. BURNETT: And I would say, Doctor
5 Alexander, answer as you see fit. If you feel like
6 her question is not fair or that you need to add
7 context, please do so.

8 Q. Again, Doctor Alexander, my question is --
9 and we will get to the -- to the plan that you have
10 in place in this case and the interventions and
11 programs that you are proposing.

12 But with respect to the individuals
13 who may benefit from such a plan, from your
14 perspective, those individuals are anyone with
15 opioid use disorder and it doesn't matter whether
16 or not they ever used a prescription opioid. Is
17 that correct?

18 MR. BURNETT: Objection.

19 Wait, did we lose the witness --

20 VIDEO OPERATOR: Yeah, we lost the
21 witness. Let's go off the record real quick.

22 MR. BURNETT: Okay.

23 VIDEO OPERATOR: The time is 11:30.
24 We are now off the record.

1 (A discussion was had off the record
2 after which the proceedings continued
3 as follows:)

4 VIDEO OPERATOR: The time is 11:33, we
5 are now back on the record.

6 BY MS. GEIST:

7 A. I apologize, Ms. Geist. I apparently was
8 booted from the wi-fi network, but I'm back.

9 And I believe where we left off, I
10 wanted to apologize, you know, for anything that's
11 long-winded and do want to try to provide you with
12 the information that you need.

13 If there's any further question that
14 you'd like to ask me about where we left off, I'm
15 happy to try to answer.

16 Q. Well, and I -- I appreciate that, Doctor,
17 very much. So thank you for that.

18 I think I'm asking what I hope is a
19 pretty simple question, but let me try it again.

20 In your proposed abatement plan that
21 you're putting forward on behalf of plaintiffs in
22 this case, in terms of treatment, the treatment
23 aspects of the program, it does not matter whether
24 or not an individual with opioid use disorder ever

1 used a prescription opioid. Isn't that true?

2 A. Yes, that is true.

3 Q. Okay, thank you. And I assume you will
4 agree with me that there are likely individuals in
5 Cabell County/Huntington who have opioid use
6 disorder who have never used a prescription opioid.
7 Do you agree with me on that?

8 MR. BURNETT: Objection.

9 A. Yes, I believe that's likely. Although the
10 -- the oversupply of prescription opioids has
11 changed -- it affects local markets for other
12 products, including heroin, so you know, we had a
13 long discussion around causation, and I'm -- I
14 don't want to, you know, have that discussion all
15 over again unless it's helpful for you, but I guess
16 my point is that even somebody who uses heroin de
17 novo could potentially be using it because of local
18 heroin markets that have flourished because of the
19 number of individuals who have developed opioid use
20 disorder from the oversupply of prescription
21 opioids.

22 Q. Under -- understood. But you agree with
23 me, I assume, that there's certainly people in
24 Cabell County/Huntington who would be beneficiaries

1 of your proposed plan should -- should any aspect
2 of it be ordered by the Court, there are
3 individuals who are heroin users who have never
4 touched a prescription opioid. Correct?

5 MR. BURNETT: Objection.

6 A. There may be such individuals, but I think
7 it's harder to know, for example, whether they
8 would not have developed heroin use or heroin use
9 disorder but for the oversupply of prescription
10 opioids into the community.

11 Q. But again, just so I'm sure I have an
12 understanding of your answer, there could be
13 individuals in Cabell County/Huntington who would
14 be beneficiaries of your plan, should that plan go
15 forward, who have never used a prescription opioid
16 ever?

17 You agree with me on that?

18 MR. BURNETT: Objection, asked and
19 answered.

20 Q. Same -- so those are with respect to heroin
21 users. I assume that you will agree with me that
22 there could be fentanyl or carfentanil users who
23 would be beneficiaries of your plan should that go
24 forward who had never, in the past, used a

1 prescription opioid?

2 MR. BURNETT: Objection.

3 Q. You agree with me on that?

4 A. My abatement plan is to address the opioid
5 epidemic and I don't think it's good science or
6 good public health to -- to try to compartmentalize
7 interventions.

8 Heroin and prescription opioids are
9 much more similar than they are different in many
10 important ways, as we've discussed, and I also --
11 it's also the case that -- that the oversupply of
12 prescription opioids has impacted the heroin market
13 and the local markets for other substances.

14 But yes, it's certainly the case that
15 there may be recipients of, say, improved treatment
16 access or recipients of naloxone after an overdose
17 that receive interventions who have not used
18 prescription opioids themselves before initiating
19 heroin use.

20 Q. And following along that line, there may be
21 individuals who are users of heroin, fentanyl or
22 carfentanil, all illicit opioids, who used
23 prescription opioids in the past but in a
24 nonmedical way and not under the care and treatment

1 of a physician.

2 Do you agree with me that these
3 individuals would also be beneficiaries of your
4 plan?

5 MR. BURNETT: Objection.

6 A. I mean, I -- we -- we could discuss -- and
7 there is helpful information on the ways that
8 opioids are used medically and nonmedically and the
9 sources of nonmedical use, and it turns out - as
10 you may be aware - that many individuals that use
11 opioids nonmedically get them from friends or
12 family that, in turn, get them from licensed
13 prescribers.

14 So I think that's an important sort of
15 conversation to have, but yes, there are
16 individuals that could receive services or
17 treatment that I suggest that may use heroin or
18 fentanyl or carfentanil that was preceded by
19 nonmedical prescription opioid use, that didn't
20 arise directly from a licensed prescriber.

21 Q. And because you've mentioned it a couple
22 times, Doctor Alexander, and you're a medical
23 doctor, I assume you agree with me that the
24 molecular structure of methamphetamine is not a

1 close chemical analog to opioids.

2 Is that correct?

3 MR. BURNETT: Objection.

4 A. I mean, I've not looked at the molecular
5 structure and compared it. The information about
6 OxyContin and heroin came from the Nora Volkow and
7 the national directors of health, and there's a
8 very compelling graphic that -- that -- in which
9 she lines these up and shows that you essentially
10 are just like flipping one carbon molecule and
11 moving a hydroxyl group over or something like
12 that.

13 So I've not compared the organic
14 chemical structure of methamphetamine and opioids
15 in order to be able to address your question.

16 Q. So let me just make sure I understand. I
17 understand you haven't done a thorough analysis,
18 but it's pretty well known, isn't it, that
19 methamphetamine is not a close chemical analog to
20 opioids?

21 I mean, we can agree --

22 MR. BURNETT: Objection.

23 Q. -- on that, can't we?

24 MR. BURNETT: Objection. This is

1 outside the scope of his report. He said that he's
2 not testifying as to methamphetamine.

3 Q. Meth is -- methamphetamine is chemically
4 different from opioids. Can we agree on that?

5 A. Yes, it is.

6 Q. Okay. Thank you. Doctor Alexander, going
7 back to my earlier questions about people in the
8 community who have OUD and never used a
9 prescription opioid, do you also agree that there
10 are individuals in Cabell County/Huntington who
11 have HIV and have never used a prescription opioid?

12 A. Yes.

13 Q. Are there also individuals in Cabell
14 County/Huntington who have Hepatitis or Hep C and
15 have never used a prescription opioid?

16 A. I'd like to qualify my last answer. I
17 would believe so.

18 And that's how I would respond to this
19 query about Hepatitis C also. Keep in mind that an
20 incredibly large number of individuals receive
21 opioids at some point in time.

22 So many, many individuals receive -- I
23 mean, a remarkably high number of individuals
24 receive a prescription for opioids at some point in

1 time. So I would have to carefully look at the
2 evidence base in order to -- in order to more
3 definitively answer your question.

4 But yes, that's -- that's my reply.

5 Q. Doctor, do you agree with me that there are
6 likely individuals in Cabell County/Huntington who
7 have infectious endocarditis and have never used a
8 prescription opioid?

9 A. Yes, I believe that's probably the case.

10 Q. In terms of individuals in Cabell
11 County/Huntington who are intravenous drug users
12 who have acquired HIV, Hepatitis C or infectious
13 endocarditis, can you agree with me that those
14 intravenous drug users are using illicit opioids,
15 either heroin, fentanyl or carfentanil?

16 A. Well, if --

17 MR. BURNETT: Objection.

18 A. If they're intravenous drug users and
19 they're using opioids, then they're either crushing
20 and injecting prescription opioids or they're
21 injecting nonprescription opioids.

22 Q. Okay. These are not individuals who are
23 users of opioids prescribed and under the care of a
24 physician for treatment. Correct?

1 MR. BURNETT: Objection.

2 Mischaracterizes the testimony.

3 A. They may be --

4 Q. Let me ask -- go ahead. I'm sorry. Go
5 ahead.

6 A. I was going to say, they may be; and they
7 may not be. I mean, I don't think that one can
8 conclude that just because someone is using
9 intravenous opioids that they're not simultaneously
10 using prescription opioids.

11 And the source of those prescription
12 opioids may be individual prescribers with direct
13 engagement with those prescribers, or it may be
14 through friends or family or through dealers. You
15 know, there are many different potential sources of
16 those opioids.

17 Q. But I assume you would agree with me that
18 all intravenous drug users in Cabell
19 County/Huntington, if they are using opioids,
20 they're using it in a legal or illicit way.

21 MR. BURNETT: Objection.

22 A. It may not be the only source of opioids
23 that they're using, but if they are injecting -- if
24 you are asking whether injecting opioids is

1 illegal, the answer is yes.

2 I mean, unless it's done under the
3 care of a licensed health care provider. But --
4 but generally and typically here, we're talking
5 about individuals that are -- that are injecting
6 opioids because they're addicted, and because, you
7 know, opioid addiction is, you know, characterized
8 by powerful compulsions to use with incredible
9 dysphoria when one undergoes withdrawal.

10 And this is why -- this is one reason
11 why the epidemic has been so devastating.

12 MS. GEIST: Let me ask our litigation
13 technology expert if he has the document I had sent
14 that we can publish as an exhibit, Exhibit 2?

15 John, do you have that and are able to
16 publish it to the witness, please?

17 MR. BURNETT: Exhibit 2 -- Exhibit 2
18 was his deposition transcript.

19 MS. GEIST: Exhibit 3. Sorry, my bad.
20 Exhibit 3.

21 MR. BURNETT: Do you want us to open
22 the tab, the envelope?

23 MS. GEIST: No, Counsel, just for the
24 record, Doctor Alexander expressed a number of

1 times wanting to look at the document that he cited
2 in his report from the West Virginia Department of
3 Human Resources, so I would like to show that to
4 him since it is cited in his report and we talked
5 about it quite a bit if that is agreeable.

6 MR. BURNETT: Subject to Doctor
7 Alexander confirming, if he can, that it's the same
8 document that he cites.

9 MS. GEIST: Sure.

10 VIDEO TECH: I'm currently pulling
11 down that document now. This is John Matthews,
12 your tech support. I need a few moments to pull it
13 up on the screen.

14 MS. GEIST: Thank you.

15 MR. BURNETT: Counsel, are you getting
16 that document from the materials we provided by
17 Sharefile or from the Internet or --

18 MS. GEIST: Yes. So --

19 BY MS. GEIST:

20 Q. Just for the record, Doctor Alexander, I am
21 referring to the document that you refer to on page
22 11 of your report at Footnote 105, and this is the
23 West Virginia Department of Health and Human
24 Resources report on overdose deaths appear to be

1 declining" dated September 5th, 2019.

2 MR. BURNETT: Same question. Are you
3 getting that here from the Internet link here in
4 the footnote, or are you getting that from the
5 materials we provided?

6 MS. GEIST: Does it make a difference?

7 MR. BURNETT: It may in terms of his
8 ability to confirm that that is the same document
9 that he used.

10 MS. GEIST: Okay. Well, can we -- can
11 we put it up on the screen and see what Doctor
12 Alexander has to say?

13 A. Is this related to Tab 3, or unrelated to
14 Tab 3?

15 Q. Unrelated to Tab 3.

16 A. Okay.

17 ALEXANDER DEPOSITION EXHIBIT NO. 3

18 (WV DHHR publication, "Gov. Justice -
19 DHHR Data Suggests West Virginia
20 Overdose Deaths Appear to be
21 Declining" dated 9-5-19 was marked for
22 identification purposes as Alexander
23 Deposition Exhibit No. 3.)

24 Q. Here we go. So Doctor Alexander, I asked

1 you some questions earlier about whether you had
2 reviewed the data from the West Virginia Department
3 of Health and Human Resources that was reporting on
4 preliminary anticipated final data from 2018 fatal
5 drug overdoses. Do you remember those questions?

6 A. I'm sorry, can you please ask me that
7 again?

8 Q. Sure. Earlier in your deposition, we were
9 looking at page 11 of your expert report, Paragraph
10 29, and you say in your report that there are
11 "glimmers of hope with preliminary data suggesting
12 a 22 to 26 percent decline in opioid overdose
13 deaths between 2017 and 2018 in Cabell County
14 specifically."

15 Do you remember that discussion?

16 A. Yes, I do.

17 Q. You have a citation there for this
18 discussion, and I did not show it to you at the
19 time, so I would like to do that now, because I
20 think you asked me if you could see the underlying
21 document, given how many citations there were in
22 your report.

23 And if --

24 MS. GEIST: Can we just go to the

1 second page, please, so I can direct Doctor
2 Alexander to where his --

3 MR. BURNETT: First of all, I would
4 suggest confirming that this is the same document
5 that's cited in his report.

6 MS. GEIST: Can we go to the third
7 page, John, please? Maybe pop out the first couple
8 bullets?

9 Q. Doctor Alexander, this is what I was
10 referring to earlier in your deposition where you
11 wrote in your report citing to this report from
12 West Virginia Department of Health and Human
13 Resources that "Cabell will see between a 22" "and
14 26% decline in overdose deaths."

15 Do you see that?

16 A. Yes, I do.

17 Q. Okay. Do you remember this -- this data
18 that was reported from the Department of Health and
19 Human Resources last year?

20 MR. BURNETT: Objection.

21 A. Yes, I believe I do. Yes.

22 Q. Okay. I mean, is this familiar to you?
23 I'm not trying to trick you. This is cited in your
24 -- in your footnote in your report. So I -- I just

1 want to make sure that this document is familiar to
2 you.

3 A. Yeah, yeah. I mean, if you could go to the
4 first page, I guess I'd like to just see the -- see
5 the first page again.

6 Q. Sure.

7 A. And then --

8 Q. So --

9 A. Yeah.

10 Q. Yeah, so for the -- for the record, the
11 document, you know, describes the release of
12 information from the West Virginia Department of
13 Health and Human Resources on "preliminary data on
14 2018 fatal drug overdoses that suggests a leveling
15 off or decrease in overall deaths."

16 And then if we look further down the
17 document, there is a specific data point reflecting
18 the decrease, and then here, Doctor Alexander, this
19 is where the Department of Health and Human
20 Resources has an analysis, graphically shown, of
21 preliminary data and what they anticipate will be
22 the final data.

23 And it does show a decrease of
24 overdoses in 2018. Is that right?

1 MR. BURNETT: Objection.

2 A. Yeah, it appears that while preliminary and
3 while estimate -- while underestimating the total
4 overdose deaths -- I'm reading the footnote here
5 that calls out -- so the data is preliminary and it
6 underestimates the total overdose deaths.

7 Q. Right. They are anticipating or estimating
8 that the final overdose -- overdose deaths will be
9 approximately 952, which is still a comparative
10 decrease from the prior year. Correct?

11 MR. BURNETT: Objection.

12 Q. Is that yes?

13 A. Yes. Yes, it is.

14 Q. And then if we look underneath the graphic
15 chart here, there's a discussion about Shifts in
16 Drug Use. Do you see that?

17 A. I do. I do. I mean, I think an important
18 point to keep in mind about numbers year over year
19 is that they're -- I mean, there are a lot of
20 different data points that one uses as an
21 epidemiologist in order to understand the nature of
22 a problem as complex and multi-faceted as the
23 opioid epidemic.

24 So I don't -- I -- so I don't disagree

1 that the preliminary 2018 data on -- on overdose
2 deaths suggests, you know, declines.

3 And I think those are welcome. But I
4 wouldn't want to, you know, infer from that some
5 broader more general conclusion about sort of the
6 nature of the -- of the problem that's faced within
7 the community.

8 Q. You're not aware of any data that shows any
9 preliminary or final analysis that indicates that
10 there is not continued decrease in overdose deaths
11 in West Virginia in 2019 and 2020, are you?

12 MR. BURNETT: Objection.

13 A. I'm sorry, that was a -- a -- I didn't -- I
14 mean, the question was --

15 Q. If my question's bad, I'll rephrase.

16 A. Yeah.

17 Q. Are you aware of any data that indicates
18 anything other than a continued decrease in
19 overdose deaths in West Virginia in 2019 and 2020?

20 MR. BURNETT: Objection.

21 A. Yes, I am.

22 Q. And what is that?

23 A. Well, I think we already discussed one
24 source of data, which is EMS calls, which I believe

1 have increased.

2 So Cabell County EMS reported that the
3 number of overdoses that they responded in May 2020
4 were two to three times higher than in the prior
5 nine months.

6 But we also know that the -- the COVID
7 pandemic has significantly threatened gains that
8 have been made in reversing opioid-related
9 morbidity and mortality and many, many communities
10 have reported strong upticks in overdose deaths
11 from opioids during the pandemic.

12 So I think there is a number of --
13 well, as I said in my report - which I would stand
14 by - for every glimmer of hope, there are also
15 signs of significant work and a long road that lies
16 ahead.

17 Q. So a few follow-ups to what you just said.
18 So in terms of the recent reports and calls -- I
19 think you were referring to Cabell County emergency
20 department visits; is that right?

21 A. EMS calls.

22 Q. EMS calls. You're not aware of any annual
23 analysis of data from 2019 indicating an overall
24 increase. Is that correct?

1 MR. BURNETT: Objection.

2 Mischaracterizes the testimony.

3 A. I don't believe that data is available, but
4 should it become so or should it be available, I
5 would be happy to advise the courts regarding my
6 take on it.

7 Q. And the same with 2020, there's no data
8 available to show an overall -- indicating an
9 overall increase in overdose deaths in West
10 Virginia or Cabell County in the calendar year of
11 2020? You're not aware that that data exists.
12 Isn't that true, Doctor --

13 MR. BURNETT: Objection.

14 Q. -- Doctor Alexander?

15 MR. BURNETT: Objection, calls for
16 speculation.

17 A. These -- you know, we don't rely upon a
18 single source of data in the work that I do. And
19 annual data, while valuable, can lag. So data
20 points such as the one that I cited can be quite
21 valuable even if it's not annual or finalized. One
22 --

23 Q. I under -- I understand what you're saying.
24 My question simply was: We don't have annual data

1 from 2019, or even preliminary data, looking at
2 annual rates of overdoses in 2020?

3 MR. BURNETT: Counsel, I would remind
4 you to please not interrupt the witness. I don't
5 believe he was finished with his answer.

6 Q. That's all I'm asking, Doctor Alexander.
7 Can we agree on that, that data does not exist?

8 A. I'm not aware of those sources of data, but
9 I think there are plenty of reasons for significant
10 concern about the state of the county and city with
11 respect to the ongoing opioid epidemic.

12 Q. Now, you had -- I'm looking at the top of
13 page 11 of your report.

14 MS. GEIST: I do -- I do want to keep
15 this document up yet, John, thank you.

16 Q. But Doctor Alexander, if you could go to
17 the top of page 11 of your report, is this what you
18 were referring me to when you said that there had
19 been overdose visits specifically in Cabell County
20 between January 2019 and March 2020?

21 A. Where -- where -- can you show where in my
22 report, what paragraph and line you're referring
23 to?

24 Q. Yeah, I'm on the top of page 11 of your

1 report, and it's the end of Paragraph 25.

2 A. No, the -- the -- if you're asking about my
3 recent point about EMS calls, it's -- it's at the
4 top of page 12, and it's sort of almost all the way
5 through Paragraph -- I'm sorry, it's the last
6 sentence of Paragraph 29.

7 Q. I see. Okay. Well, let me ask you a
8 couple questions. First, beginning on your data
9 point at the top of page, end of Paragraph 25, here
10 you write, "Between January 2019 and March 2020,
11 there were 122 overdose-related visits to Cabell
12 County" Emergency Departments "for youth aged 19
13 years and younger."

14 Do you see that?

15 A. Yes, ma'am.

16 Q. Do we know what percentage or how many of
17 those overdose-related visits were due to the use
18 of opioids as opposed to other illegal substances,
19 other drugs?

20 MR. BURNETT: Objection.

21 A. I would --

22 MR. BURNETT: And again, Doctor
23 Alexander, if you need to look at the document to
24 answer the question, please do so.

1 A. Yeah, I would want to look -- if you're
2 asking what the source of the overdose was for
3 these 122 visits among youth aged 19 years or
4 younger, it would be helpful to review Reference 94
5 together.

6 Q. But -- and maybe we'll do that. But for
7 now, I mean, this is your report. That is your
8 statement in your report, correct?

9 A. Yes, ma'am.

10 Q. And sitting here today, you can't tell me
11 that -- that even a single one of those
12 overdose-related visits to the emergency department
13 related to opioids. True?

14 MR. BURNETT: Objection.

15 A. Well --

16 MR. BURNETT: Mischaracterizes the
17 testimony.

18 A. I think it would be highly unlikely that
19 that's the case. I reviewed all of the materials
20 that are included in my report, and I don't think
21 that I would have -- while I haven't had the
22 opportunity to review Reference 94 with you, I
23 think it's unlikely that I would have included the
24 reference if, having reviewed it -- if in fact it

1 wasn't relevant to the point that I'm making in
2 this paragraph.

3 And the point that I'm trying to make
4 is that children and adolescents haven't been
5 immune from the opioid epidemic in Cabell County
6 and the City of Huntington.

7 Q. Do you know whether any of those
8 overdose-related visits to the Cabell County
9 emergency department related to nonopioid drugs
10 such as methamphetamine or cocaine?

11 MR. BURNETT: Objection, asked and
12 answered.

13 A. It would be helpful to review the report
14 together -- the reference together if -- if you
15 have further questions about it.

16 Q. You -- Doctor, just to be -- you can't
17 answer my questions without looking at the
18 reference?

19 A. Ask me the question again, please.

20 Q. Sure. You can't answer my question without
21 looking at the reference? Is that what you're
22 telling me?

23 A. Can you --

24 MR. BURNETT: Objection.

1 A. -- give me the preceding question again,
2 please?

3 Q. Sure, sure. I think the question was,
4 sitting here today, this statement is in your
5 report, and what I would like to know is if you can
6 tell me if any of those overdose-related visits to
7 the Cabell County emergency department related to
8 the use of methamphetamine or cocaine?

9 MR. BURNETT: Objection, asked and
10 answered.

11 A. So I think it's likely that some did. I
12 mean, either I should have clarified that these
13 were opioid overdoses alone, but without the
14 opportunity to review the reference, I can't tell
15 you whether or not that was, you know, an oversight
16 on my part.

17 But unless that's the case -- if you
18 told me that 122 children age 19 years and younger
19 visited the emergency department for overdose in
20 this community, I would expect that some of them
21 visited the -- visited the emergency department for
22 nonopioid-related overdoses, yes.

23 Q. And do we know if any of them visited the
24 emergency department in Cabell County based on the

1 use of prescription opioids as prescribed by a
2 doctor?

3 MR. BURNETT: Objection. Counsel, the
4 witness has told you many times now he would need
5 to see the document to answer these sorts of
6 questions.

7 THE DEPONENT: Thank you.

8 A. Yeah, I feel -- I'm happy to sort of - at
9 the highest level - try to be helpful and provide
10 you with my take, but really, if you're asking
11 detailed questions about how these 122 individuals
12 came to overdose, it would be helpful to review
13 this specific reference, keeping in mind that there
14 are more than 650 references within this report and
15 -- and that I relied upon all of these in order to
16 reach my conclusions.

17 Q. Now, if you'd turn to the next page of your
18 report, Doctor --

19 MS. GEIST: And John, leave this up on
20 the screen, because I'm going to get back to it.

21 Q. But if you turn to the next page on your
22 expert report, Doctor, the top of page 12, you had
23 referred me to that data point, in terms of the
24 number of calls from EMS and Cabell County?

1 A. Yes, ma'am.

2 Q. And do you attribute that to the COVID
3 pandemic and the related need for isolation and
4 stay-at-home orders and things of that nature?

5 MR. BURNETT: Objection.

6 A. I -- I am not sure without much more review
7 and analysis of precise attribution. I think
8 what's noteworthy is that this data point suggests
9 that -- that -- it's one of many data points that
10 suggests that there's still significant concern
11 about the potential for opioid-related morbidity
12 and mortality within Cabell County and the City of
13 Huntington.

14 Q. Is -- are you aware if any of those EMS
15 calls were responding to any increase in overdoses
16 from the use of prescription opioids?

17 A. Again, as with all --

18 MR. BURNETT: Objection.

19 A. I mean, as with all of these questions
20 about statements in my report, it's always helpful
21 in order -- it's always helpful to be able to
22 review the report itself and the references with
23 you.

24 So if this is a reference and a data

1 point that's of particular interest, I'm happy to
2 review it with you.

3 Q. Okay. So sitting -- but sitting here today
4 - without looking at the data source - you can't
5 answer my question as to whether any of those calls
6 that EMS had to respond to related in any way to
7 the use of a prescription opioid?

8 MR. BURNETT: Objection.

9 A. Correct, I don't -- I don't have
10 information top of mind about how the higher rates
11 of calls recently break down across different types
12 of opioid products, for example.

13 Q. Okay. Let's go back to what we're still
14 looking at on the screen, which we have now marked
15 as Exhibit 3. And then again following on Exhibit
16 3, Doctor Alexander, the Department of Health and
17 Human Resources discusses also in this report what
18 they call "shifts in drug use." Do you see that?

19 A. Yes, I do.

20 Q. And the first line indicates that most
21 individuals who die of an overdose, most of the
22 individuals are using more than one drug in the
23 overdose. In other words, this is referred to as
24 poly pharmacy or poly drug use; is that right?

1 MR. BURNETT: Objection.

2 Mischaracterizes the document.

3 A. I do see that -- that -- that the document
4 reports that "For most" "who die, more than one
5 drug is detected," and I see it calls out that
6 "Opioids" "are still the most common type of drug
7 seen," "with over" 80 percent of opioids involved
8 in "overdose deaths in 2018."

9 Q. So let's -- let's talk about that. I was
10 going to ask you anyway. So you read my mind.

11 In terms of the over -- of the "82% of
12 overdose deaths in 2018" relating to opioids,
13 there's some specific data right below that about
14 that sentence, correct?

15 A. Yes.

16 Q. In other words, 82 percent of the overdose
17 deaths in 2018, according to this data, that
18 related to opioids involved only illicit or illegal
19 opioids, specifically fentanyl and heroin.

20 Correct?

21 A. Where -- where are you pointing where it
22 says that they involved only fentanyl or heroin?

23 Q. So if you look -- what's highlighted here
24 is what you said, is that "Opioids were involved in

1 82% of overdose deaths in 2018," and then under --
2 "this is a decline from 2017." And underneath
3 that, it states, "Fentanyl and heroin remain the
4 most common opiates seen in overdoes deaths (59%
5 and 23% of deaths involved these substances
6 respectively in 2018)."

7 Do you see where I --

8 MR. BURNETT: So I object to the
9 characterization of the document. It does not
10 refer to the word "only."

11 Q. Do you see where I am?

12 A. I do see where you are, but I was going to
13 make the same point, that I'm not sure I can
14 conclude from this that fentanyl or heroin -- and
15 heroin are the only products. But I think the
16 larger point is that -- although so I -- so I do
17 see what you're saying here.

18 Q. Yeah, okay. So whether or not the data
19 tells us that fentanyl and heroin were the only
20 products, we know that fentanyl and heroin were
21 indeed involved in 82 percent of overdose deaths in
22 2018. Is that fair?

23 A. No, I don't think that's --

24 MR. BURNETT: Yeah.

1 A. -- the case.

2 MR. BURNETT: Objection.

3 Mischaracterizes the document.

4 Q. You don't agree with me, Doctor Alexander?

5 A. Correct, I do not.

6 Q. Why not?

7 A. Because I believe you said that the
8 document suggests that fentanyl and heroin were
9 involved in 82 percent of overdose deaths in 2018,
10 and I don't see that the document says that.

11 What I read it as saying is that
12 "Opioids were involved in 82 percent of overdose
13 deaths in 2018."

14 Q. And then just -- just to clarify for the
15 record, below that, it says that "59% and 23% of
16 deaths involved" either fentanyl or heroin "in
17 2018." Is that correct?

18 A. Yes.

19 Q. All right. So we know from that that 82
20 percent of the overdose deaths in 2018 involved
21 illegal or illicit opioid substances. True?

22 MR. BURNETT: Objection.

23 Mischaracterizes the document.

24 Q. Well, fentanyl and heroin, as indicated

1 here, are not legal substances. True?

2 A. Yes, that's true. But it's not clear to me
3 that this is either/or; in other words, that these
4 categories are mutually exclusive. So it may well
5 be that someone has discernible in their blood
6 system both heroin and fentanyl, and so if that 59
7 percent and 23 percent aren't mutually exclusive,
8 but overlap, then I don't think one would reach the
9 conclusion that 82 percent of overdose deaths
10 involved -- of opioid overdose deaths, involved
11 fentanyl and heroin.

12 Q. Now, above these two bullets that we've
13 been looking at, there's a discussion about
14 methamphetamine. Correct?

15 A. Yes.

16 Q. And the West Virginia Department of Health
17 and Human Resources reports that "The percentage"
18 of over -- "of overdose deaths involving
19 methamphetamine" continues "to increase," and now
20 in 2018, "More than one-third," or "36%," "of drug
21 overdose deaths," "involved methamphetamine."

22 Is that correct as I read it?

23 A. Yes. In West Virginia, yes, I believe so.

24 Q. And that this continues to be a significant

1 -- or rather --

2 MS. GEIST: Strike that.

3 Q. "This continues a significant and rapidly
4 rising trend seen in recent years" and then it
5 shows some statistics from 2014 to 2018, a 33
6 percent increase over those five -- five calendar
7 years.

8 Is that accurate?

9 MR. BURNETT: Objection,
10 mischaracterizes the document.

11 A. I mean, it notes that -- it does note an
12 increase in methamphetamine-related overdose
13 deaths, and also notes that more than half of these
14 involved fentanyl.

15 I think it's important to keep in
16 mind, this is at the State level, so it may or may
17 not be that the data applies similarly to Cabell
18 County and the City of Huntington, although I
19 wouldn't be surprised to know that there are
20 similar increases.

21 They may not be identical, but similar
22 increases. Or important increases like this within
23 the community that -- that we're really focused on.

24 But I -- again, you know, we discussed

1 earlier my sense that there was a bit of a
2 potential perception for a false dichotomy. You
3 know, is this a methamphetamine problem or is this
4 a fentanyl problem or is this a opioid problem or
5 is this a nonopioid problem?

6 And you know, what I was asked to
7 evaluate is the extent of an opioid epidemic within
8 Cabell County and the City of Huntington and to
9 design an evidence-based longitudinal and
10 comprehensive abatement plan to address it.

11 So I don't view -- I think that these
12 trends are important and that any abatement plan
13 that's going to be successful has to be conducted
14 mindful of the -- of the local context in which
15 opioids are being used, but I -- but I don't view
16 these data points as sort of diminishing the
17 importance of the plan that I've proposed.

18 Q. I understand your point. My question is:
19 In terms of the increase in methamphetamine in West
20 Virginia, from 2014 to 2018, there's a 33 percent
21 increase in methamphetamine. Correct? In overdose
22 deaths, I should say.

23 MR. BURNETT: Objection,
24 mischaracterizes the document.

1 A. So I read this as based on preliminary drug
2 overdose data from 888 individuals at a state level
3 at one year, one point in time, there was noted,
4 you know, about a third of overdoses involved
5 methamphetamine.

6 Q. Is that -- does that indicate that there is
7 a methamphetamine-related epidemic in West
8 Virginia --

9 A. Well, I --

10 Q. -- if these --

11 A. I wasn't asked to opine about a
12 methamphetamine epidemic and so I wasn't -- that's
13 not what I was asked to do.

14 Q. Do you think it is a significant increase
15 to go from 3 percent overdose deaths involving meth
16 in 2014 all the way to 36 percent in 2018?

17 MR. BURNETT: Objection.

18 A. Without a doubt. Without a doubt. I think
19 that's significant. And one of my concerns is that
20 many of these individuals may have opioid use
21 disorder, and that with inadequate funding and
22 support to expand and deploy and scale up
23 evidence-based treatment programs for opioid use
24 disorder, individuals are -- you know, we're paying

1 the price, and this may well be -- although not the
2 focus of my report, I certainly have concern
3 insofar as individuals may be engaging in, you
4 know, methamphetamine use or other substance use
5 who have untreated opioid use disorder.

6 Q. But we don't know, Doctor, do we, that in
7 looking at this data that these individuals have
8 opioid use disorder, do we?

9 A. Well --

10 MR. BURNETT: Objection.

11 A. No, these data are overdose data, so you
12 can't use overdose data to identify whether or not
13 someone has addiction. No.

14 Q. And if -- if you look further down, there
15 is a discussion regarding "the presence of
16 prescription medications" in the 2018 overdose
17 death analysis. Do you see where I am? It starts
18 "In general"?

19 A. Yes. I do.

20 Q. And it indicates that "the presence of
21 prescription opioids in those dying of overdose
22 continues to decline." Did I read that correctly?

23 MR. BURNETT: Objection.

24 A. Yes.

1 Q. And then "The most common medications seen
2 in overdose deaths" in 2018 relate to Oxycodone, 10
3 percent, which is a significant decrease from 2014.
4 Is that right?

5 MR. BURNETT: Objection.

6 A. Yes, I read it as "Oxycodone (10% in 2018,
7 down from 32 percent in 2014").

8 Q. And there's no indication here that the
9 presence of oxycodone - based on, I would presume,
10 a toxicology report - was there from a
11 prescribed --

12 MS. GEIST: Strike that.

13 Q. There's no indication from this data that
14 the presence of oxycodone was medication that was
15 prescribed by a physician as opposed to oxycodone
16 bought off the street or stolen or taken out of a
17 medicine cabinet. True?

18 MR. BURNETT: Objection.

19 A. I don't think one can tell from toxicology
20 data such as this what the source of -- of opioids
21 were, but again, as I think we've discussed
22 previously, the -- there's a lag between when, at a
23 population level -- there are -- there are
24 immediate effects of the oversupply of prescription

1 opioids, but there are also lag effects.

2 Just as if -- as if you take a
3 community and 60 percent of the people in the
4 community start smoking cigarettes, they're not
5 going to drop dead tomorrow. It takes a while --
6 it takes years to see the manifestations in the
7 case of tobacco, lung cancer, heart disease,
8 stroke, emphysema and the like.

9 And so there are similar lag effects
10 that take place with an oversupply of prescription
11 opioids. And so I wouldn't necessarily expect to
12 see the effects of an oversupply of opioids. All
13 of the effects aren't going to manifest in the
14 first 24 hours or the first week or the first
15 month.

16 So my point is that while I think
17 these trends are heartening in some sense insofar
18 as they may suggest declines in the presence of
19 prescription opioids and in these unfortunate
20 individuals who have died, by no means would I use
21 this single data point to draw some conclusion
22 regarding the nature of the opioid epidemic in
23 Cabell County and the City of Huntington.

24 Q. Doctor Alexander, I'm going to turn now to

1 the specific components of your proposed abatement
2 plan, to use your words.

3 A. Okay.

4 Q. Okay? So let me mark -- before we get
5 there, let me make sure I have all of the aspects
6 of your expert report sort of marked for the
7 record. So -- and let you have all of those
8 materials in front of you when I ask you questions.

9 So if we look at your expert report -
10 which again is Exhibit 4 - I guess it's the second
11 page of that report, you list a number of documents
12 that you included as Appendix A, B, C and D as in
13 dog.

14 Do you see that?

15 A. I do.

16 Q. Okay. So I think Appendix A, we have
17 separately included in the envelope that was marked
18 either Tab 5 or Exhibit 5. Do you have that in
19 front of you, Doctor?

20 A. Yes, ma'am.

21 Q. Okay. And then your curriculum vitae is
22 included as part of your report. I just wanted to
23 ask you, Doctor, quickly on your CV, do you need to
24 make any changes or update it in any way?

1 A. Well, I've had -- I'm sure that I've had
2 some papers accepted for publication or published
3 since the last time that it was submitted, so I
4 don't -- I will follow your lead and that of the
5 plaintiffs' counsel as to whether those are
6 important changes to make.

7 I don't believe that I have -- I mean,
8 I've accepted invitations to speak at one or two
9 national conferences, so there are -- probably
10 week-to-week, there are very modest changes that I
11 could make. But I think overall this represents
12 fairly well the totality of my professional
13 activities.

14 Q. Thank you, that's fine. And we'll just
15 make a request for an updated CV at some point
16 prior to trial.

17 A. Of course.

18 Q. Appendix C, that is the list of sources
19 that were consulted in connection with your
20 opinions formed in the case. And that is Exhibit
21 7, along with -- or Tab 7, along with Appendix D,
22 which is your redress model.

23 And Doctor Alexander, would you mind,
24 if you have those two envelopes in front of you? I

1 just want to make sure that Tab A is -- is Exhibit
2 5, which is your John Hopkins report; and then Tab
3 7 is the list of sources that were consulted in
4 your redress model.

5 A. Yeah, so I opened -- and by the way, I
6 would appreciate maybe within ten or fifteen
7 minutes a brief break, would be great --

8 MR. BURNETT: Yeah, Counsel, I was
9 going to suggest not a brief break, but why don't
10 we break for lunch before we get into these other
11 documents? Since we've been going about an hour
12 and a half, and it's 12:20.

13 MS. GEIST: Yeah, absolutely, Counsel.
14 What I'm doing right now is I'm just trying to get
15 ready -- because I'm looking at the clock too, and
16 I know we're going to want a lunch break.

17 I want to get into Doctor Alexander 's
18 opinions in the report. So I'm trying to make sure
19 we're -- we're ready to do that.

20 So I want him to have in front of him
21 his list of sources that he consulted and his Johns
22 Hopkins report that was Appendix A, and his redress
23 model. Together with his report. That's what I'm
24 trying to do now.

1 A. Yeah, so I had -- I think I was asked to
2 open Tabs 4, 5 and 7. And so those are -- I have
3 opened in front of me. So Tab 4 is -- is that
4 what's being displayed?

5 Q. No. Tab 4, Doctor Alexander, should be
6 what we've marked as Exhibit 4. That should be
7 your expert report.

8 A. Okay. And may I put that away? Or shall I
9 keep that handy?

10 Q. I would keep that handy, please. Thank
11 you.

12 A. Okay. So that is Tab 4. And then Tab 5 --

13 Q. Tab 5 should be your "Johns Hopkins Report:
14 'From Evidence to Impact'," which is Appendix A to
15 your report.

16 A. Okay, so I have that available.

17 Q. And then Tab 7? And that should be your
18 list of sources that were consulted and your
19 redress model.

20 A. Right. And so that's a one-page -- that's
21 a one-page document, and I see it -- on one side,
22 it says, "Expert Witness Report of G. Caleb
23 Alexander, Appendix C, List of Sources That Were
24 Consulted," and on the other side of the page, I

1 see "Materials Considered" and it lists three --
2 there's three numbers essentially.

3 Q. Okay. We before -- before we take a break
4 for lunch, Doctor Alexander - because I do think
5 it's a good time to break - in terms of your
6 Appendix C to your report, can you just please
7 represent to us that all of the materials that you
8 reviewed and relied upon in forming your opinions
9 that are contained in your expert report are either
10 cited in the report itself or they're in your list
11 of sources that were consulted?

12 MR. BURNETT: Objection.

13 A. They could also be included in the redress
14 models. So if you're -- when you say my report, if
15 you mean both my narrative 125-page report as well
16 as the redress models that I've provided, yes, I
17 can confirm that all of the materials that I used
18 are either referenced or cited in my narrative
19 report, the 125-page report, or the redress models,
20 Appendix D on what's being displayed currently, or
21 the list of sources that were consulted, Appendix
22 C.

23 Q. Thank you very much for that. The only --
24 the only other question I have before we take a

1 break is: There were some notes that were provided
2 to us at our request, and these notes are referred
3 to in your report, notes of meetings or interviews
4 that you or your team members from Monument
5 Analytics had done.

6 You had met with individuals in Cabell
7 County/Huntington. I think you referred to them as
8 local stakeholders. Is that correct?

9 A. Yes, ma'am.

10 MR. BURNETT: Objection.

11 Q. And you have -- you and/or your colleagues
12 put together some notes from at least some of those
13 meetings. Is that right?

14 MR. BURNETT: Objection.

15 A. Yes, it is.

16 Q. Okay. We have separately marked those as
17 exhibit -- or Tab 52. We might as well just take
18 that out so we're ready to review that when we come
19 back from lunch.

20 A. Okay. So I have Tabs 4 -- excuse me. 4,
21 5, 7 and 52 available and handy.

22 Q. Great. It probably would have made better
23 sense to just make it all one document, but we
24 didn't. So I apologize. And if we were in person,

1 I would just hand it all over to you. But this is
2 the nature of the -- the Zoom situation that we're
3 in.

4 So why don't we take a break for
5 lunch. How much time would you like for lunch?

6 A. Say -- what would you suggest? I'm open.

7 MR. BURNETT: How about 1:00 o'clock?

8 MS. GEIST: I don't know if you're
9 able to get lunch quickly at the hotel where you
10 are, you know, 1:00 o'clock -- we could try for
11 1:00. You want to say 1:15? I don't know if
12 you're going down to a restaurant.

13 THE DEPONENT: No, 1:00 p.m. is fine.
14 Even ten to 1:00 would be fine, but 1:00 would be
15 fine with me.

16 MS. GEIST: Okay. 1:00 o'clock.

17 MR. BURNETT: Why don't we say 1:00?

18 MS. GEIST: 1:00 o'clock.

19 THE DEPONENT: Great.

20 MS. GEIST: Very good. Thank you.

21 THE DEPONENT: Thank you.

22 VIDEO OPERATOR: The time is
23 12:27 p.m. We are going off the record.

24 (A recess was taken for lunch after

1 which the proceedings continued as
2 follows:)

3 VIDEO OPERATOR: The time is 1:01, we
4 are now back on the record.

5 BY MS. GEIST:

6 Q. Okay, welcome back, Doctor Alexander. I
7 hope you had a nice lunch.

8 A. Thank you. Yes, you too.

9 Q. Thank you. Quick but fine. If you could
10 go ahead, Doctor Alexander, and put Exhibit 5 in
11 front of you. And just for the record, you've
12 included this as an attachment to your expert
13 report in this case, and this is a 2017 report
14 entitled "THE OPIOID EPIDEMIC, From Evidence to
15 Impact," from Johns Hopkins Bloomberg School of
16 Public Health. Is that correct?

17 A. Yes, it is.

18 Q. And could you just explain to me briefly,
19 why did you attach the 2017 Johns Hopkins report to
20 the expert report in this case?

21 A. Well, this was work that was undertaken in
22 concert with the Clinton Foundation, and the focus
23 of this undertaking was to disseminate evidence-
24 based and evidence-informed approaches to abate the

1 opioid epidemic, and I thought it was relevant for
2 this purposes because it -- for a few reasons.

3 I guess the biggest two were that it
4 demonstrates some of my activity in this area, as I
5 was one of three faculty that led this initiative.

6 And also as I highlight in my expert
7 report for this case, there is remarkable alignment
8 between the types of abatement interventions that
9 are -- that are described in Appendix A and the
10 expert recommendations of many other parties,
11 including, you know, Surgeon General's reports and
12 a report from the current administration in
13 Washington, D.C. focused on abating opioid-related
14 harms and the like.

15 And so that's why I included it.

16 Q. Okay. Thank you. And I was asking you
17 that question, because I did see a number of
18 consistencies between the Johns Hopkins report and
19 your abatement plan submitted in this case and your
20 abatement plan submitted in the Ohio MDL case. So
21 that was part of the reason why I asked you.

22 Did the Johns Hopkins report, Appendix
23 A, at least loosely form the outline or the
24 thinking for what ultimately became your first

1 abatement report in this litigation?

2 MR. BURNETT: Objection.

3 A. The report is -- the Johns Hopkins report,
4 "From Evidence to Impact," is relevant for the
5 reasons that I mentioned, but each of my -- this
6 was a general report, "From Evidence to Impact,"
7 that wasn't focused on a particular community, and
8 in contrast, the report that I've provided for the
9 county of -- for Cabell County and the City of
10 Huntington is based on and motivated by and
11 informed by many of the what I would call
12 contextual dimensions of the epidemic or the fabric
13 of the epidemic as it's played out in Cabell County
14 and the City of Huntington.

15 Q. So let's take a look just quickly at page 5
16 of the Johns Hopkins report. And by the way, while
17 we're doing that, Doctor, this is not the first
18 iteration of the Johns Hopkins report, "From
19 Evidence to Impact;" is that correct?

20 A. When you say "first iteration," I mean,
21 this represents, I believe, the report that has
22 been produced as the final report that was
23 disseminated in, I believe it was, October of 2017.

24 Q. Sure. My question -- maybe my question

1 wasn't clear. There was at least an earlier
2 version of this Johns Hopkins report, "From
3 Evidence to Impact" back in 2015. Is that correct?

4 A. No, I believe --

5 (Deponent had an interruption at his
6 location.)

7 THE DEPONENT: Sorry for the
8 interruption. That's fine. Thank you very much.
9 I'm good. Thank you very much, sir.

10 A. The 2015 report was a separate report. I
11 wouldn't characterize it as an earlier version of
12 this report. It was a separate report.

13 Q. Okay. But both of these reports are
14 referenced in the expert report you've provided on
15 behalf of plaintiffs here, correct?

16 A. That may be. I mean, there were, again,
17 650 or more references, and so I would want to look
18 carefully with you.

19 But it may well be the case that I
20 referenced both the 2015 report and this 2017
21 report that we're looking at here.

22 Q. So you can quickly go to page 4 of your own
23 expert report, Doctor, just so we can clarify this,
24 because in each of your three abatement plans that

1 I have seen - the one here, the one in Washington
2 and the one in Ohio from the MDL case - both of the
3 Johns Hopkins reports or monographs issued in
4 October of 2015 and October of 2017 are -- are
5 referenced specifically in those reports.

6 There's even a picture, if you look at
7 page 4 of your expert report in this case.

8 A. I'm quite sure and recall having referenced
9 the 2017 report, and actually in the -- in the page
10 that's being projected, I see that we report that
11 this 2017 report reflects an updated and expanded
12 revision of a prior monograph, which is referencing
13 the 2015 version.

14 I guess the point that I was
15 requesting an opportunity to confirm with you was
16 whether or not the 2015 report was specifically
17 called out as a reference in my expert report. But
18 it may well have been. I think that -- that --
19 that would -- that may well be the case.

20 Q. Okay. I mean, it's on page 4 of your
21 report. I don't want to quibble with you or make
22 you think I'm trying to trick you. I'm --

23 A. Well, where -- where on page 4 is there a
24 reference -- I mean, I see that I allude to it. I

1 -- there's a sentence that reads, "These monographs
2 were issued in October 2015 and October 2017," and
3 then I say, "The latter report is provided as
4 Appendix A." Thank you.

5 But what I'm questioning is: I guess
6 I thought you were asking whether or not one of the
7 650 odd references is -- I thought you were asking
8 whether one of the 659 references is to the 2015
9 report, and that's where I was raising question as
10 to whether or not that's the case.

11 Because I don't believe it's the case,
12 but it may have been, as I said.

13 Q. No, it's just referenced -- you know,
14 frankly, I didn't cross-check it. But it is here
15 referenced as you noted on page --

16 A. No, I --

17 Q. -- page 4 of your report. Right?

18 A. Yes, it is.

19 Q. Okay. Thank you. Now, going back to the
20 Johns Hopkins "From Evidence to Impact" report that
21 you attached specifically at Appendix A, and that
22 was the October of 2017 report, if you look at page
23 5, that sort of outlines, if you will, you know, a
24 "commitment to three principles": Informing Action

1 with Evidence; "Intervening Comprehensively;" and
2 "Promoting Appropriate and Safe Use of Prescription
3 Opioids."

4 Do you see where I am?

5 A. Yes. Yes, ma'am.

6 Q. And then it indicates that "Those
7 principles led to the delineation of 10 topic areas
8 across the spectrum of the problem ranging from
9 how" physicians "treat pain to treatment for opioid
10 use disorders to harm reduction strategies." And
11 then "The findings of the report are comprised of
12 evidence from these topic areas."

13 Did I read all of that correctly?

14 A. Yes.

15 MR. BURNETT: Objection.

16 Q. And obviously you were part of the research
17 team at Johns Hopkins that did the research and put
18 together this report?

19 A. Yes, I was one of three faculty that led
20 this initiative.

21 Q. Okay. And if you look with me at the --
22 the outline of the report, the ten topic areas, the
23 first half is entitled "Improving the Safe Use of
24 Prescription Opioids" and that addresses five

1 topics, and then "The second half" includes
2 additional topics focusing "on addressing,"
3 "Identifying and Treating People with Opioid-Use
4 Disorders."

5 Do you see where I am, Doctor?

6 A. Yes, I do.

7 Q. Okay. And would you agree with me that
8 this loosely follows some of the topics that you
9 have in your expert report?

10 A. Well, there are some overlap. I'm --

11 THE DEPONENT: I'm sorry, David. Did
12 you wish to say something?

13 MR. BURNETT: I just said "Objection."

14 You can answer.

15 A. There was some overlap, and there are --
16 then there are areas where there's not so much
17 overlap. And you know, keep in mind, this was a
18 report that was generated in 2017 and was focused
19 on a national epidemic.

20 My report for this case was generated
21 earlier this year, and over the course of perhaps a
22 year, and is focused on Cabell County and the City
23 of Huntington. So there was certainly some
24 dimensions of the epidemic that are highly

1 consistent in terms of abatement between this
2 report and my report in this case.

3 But -- but there's not perfect
4 alignment either, nor would I expect there to be.

5 Q. And nor did I suggest it. My question
6 really was: Were you -- was this essentially the
7 starting point for the abatement report you put in
8 in the Ohio case involving Cuyahoga County and
9 Summit County?

10 MR. BURNETT: Objection, asked and
11 answered.

12 A. I would say it's not.

13 Q. This didn't form at all any of the bases
14 for your opinions in that initial case that you put
15 the abatement report in in March 2019 in Ohio?

16 MR. BURNETT: Objection.

17 A. I disagree with that statement. It did.
18 It did inform it. But you asked if it was the
19 starting point, and I would not characterize it as
20 the starting point.

21 I mean, keep in mind that my report
22 and my recommendations are based on a huge volume
23 of literature and an enormous scientific evidence
24 base.

1 So it's only natural, for example, if
2 I'm talking about treatment for opioid use
3 disorder, some of that literature that I would cite
4 in this 2017 report is bound to be the same as
5 literature that I would cite in my report for
6 Cuyahoga County and Summit County.

7 But I wouldn't -- I would not
8 characterize this as the starting point for my
9 report in Cuyahoga and Summit County.

10 When I'm asked to develop an abatement
11 plan for a community, the starting point is to
12 learn more about the community and understand the
13 scope and the nature of the epidemic within the
14 community that's been affected.

15 So the starting point is not
16 scientific evidence. The start --

17 Q. I apologize. That was my phone.

18 A. Oh, okay.

19 The starting point is not scientific
20 evidence; the starting point is understanding the
21 community.

22 Q. Would you agree with me, Doctor Alexander,
23 that some of these topics, these headings that
24 we're looking at here together on the screen, 1

1 through 10, some of them are identical or virtually
2 identical to the headings that appear in your
3 report?

4 A. Absolutely.

5 MR. BURNETT: Objection.

6 A. There are -- absolutely. There are some
7 broad headings and broad domains that run
8 throughout any -- any reasonable and comprehensive
9 abatement plan, things --

10 Q. I understand.

11 A. -- reading --

12 Q. Your answer was, "Absolutely," I'm correct?

13 MR. BURNETT: No, again, I believe you
14 interrupted the witness while he was answering the
15 question.

16 MS. GEIST: I just -- I'm going to
17 move to strike after "Absolutely." Because, you
18 know, I feel like there's a fair bit of
19 narrative --

20 MR. ARNOLD: Counsel, you can't --
21 this is Edward Arnold for the plaintiffs. You
22 cannot move to strike. There is no move to strike
23 here --

24 MS. GEIST: I'm going to move to

1 strike -- I can move to strike after "Absolutely."

2 MR. ARNOLD: There's no such thing.

3 MS. GEIST: My seven hours is being
4 impact by all of the long, narrative responses
5 given by Doctor --

6 MR. ARNOLD: You are giving long
7 narrative questions --

8 MS. GEIST: I --

9 MR. ARNOLD: -- so make briefer
10 questions if you want to use your time.

11 MS. GEIST: The question was: "Are
12 these identical or near identical to what's in your
13 report?" That is not a long narrative of question.

14 I've gotten paragraphs of answers in
15 the response. I'm noting for the record that the
16 seven hours is being taken up in large part by
17 Doctor Alexander expanding well beyond the question
18 posed.

19 So let's move on.

20 BY MS. GEIST:

21 Q. Doctor Alexander, I want you to go to the
22 first page of the Johns Hopkins "From Evidence to
23 Impact" document that we're looking at here.

24 MR. BURNETT: Counsel, let me

1 interject as well. I'm going to object to
2 questions that require longer answers because your
3 questions are unfair or misleading, and the witness
4 is entitled to answer as he sees fit, so I would
5 suggest you ask different questions if you're not
6 happy with his answers.

7 You're -- you know, the witness is
8 entitled to answer the question you present in the
9 best way that he thinks possible to best represent
10 his views on the question.

11 Q. I'll go back one page.

12 MS. GEIST: John, please -- sorry, I'm
13 looking for the -- it's the first or second page.
14 It has "The Clinton Foundation" at the top. There
15 we go. Thank you.

16 Q. Doctor Alexander, I assume you're familiar
17 with this page in the Johns Hopkins report?

18 A. Yes, I am.

19 Q. Okay. And do you agree with the statement,
20 it appears to be, by the Clinton Foundation and
21 signed off by Former President Bill Clinton in the
22 second paragraph which indicates that "There's no
23 single solution to this grave public health threat,
24 but we know where to start. First we must

1 acknowledge that opioid addiction is a disease that
2 requires comprehensive treatment."

3 I assume you agree with that.

4 A. Yes, I do.

5 Q. "Closing the path to addiction means
6 addressing the overprescription of legal opioids."
7 Do you agree with that?

8 A. I mean -- "Closing the path" --

9 Q. Well, let's read the whole sentence.
10 "Closing the path to addiction means addressing the
11 overprescription of legal opioids and the
12 proliferation of illicit opioids such as heroin and
13 drugs laced with fentanyl."

14 Do you agree with that sentence?

15 A. And am I -- I discuss in great detail in my
16 report what I think it's going to take to reverse
17 opioid-related harms in Cabell County and the City
18 of Huntington, and so rather than weighing in on
19 the former president's words, I would rather refer
20 to the four corners of my report, which I think
21 very well characterize what I think it will take to
22 reverse opioid-related harms.

23 Q. But the question was: Do you agree or
24 disagree with the sentence that I just read?

1 "Closing the path to addiction means addressing the
2 overprescription of legal opioids and the
3 proliferation of illicit opioids such as heroin and
4 drugs laced with fentanyl."

5 MR. BURNETT: Objection, asked and
6 answered.

7 Q. Do you agree or disagree?

8 A. I think that there are many different
9 interventions that have very good evidence to
10 support them that can be used to address the
11 thousands of people within the county that have
12 opioid use disorder, and I'm hesitant to -- to
13 simplify what is a complex phenomenon. I think
14 that --

15 Q. Doctor Alexander, I don't want to interrupt
16 you, I really don't. But it was a question that
17 was really clear and really simple. There's a
18 sentence in the Johns Hopkins report that -- you
19 were a part of that report. You chose to include
20 it as a reference material in your expert report
21 here.

22 There is a statement I just read to
23 you, and my only question, sir, is: Do you agree
24 or disagree? Can you answer that question?

1 MR. BURNETT: Counsel. Counsel,
2 number one, you're, again, interrupting him. I'm
3 -- it's too bad you're not happy with his answer,
4 but he's entitled to answer as he sees fit. If it
5 doesn't lend itself to a yes or no answer, he's
6 entitled to say that. It's his testimony.

7 Q. Not yes or no. Do you agree or disagree?
8 That's the only question. If you disagree, you can
9 tell me and you can tell me why. If you agree, you
10 can tell me that too.

11 MR. BURNETT: Same objection. He's
12 answered as he saw fit. You've now answered the
13 question three times.

14 MS. GEIST: He hasn't answered.

15 A. Let me try again. These are the former
16 president's words. They're not my own. I think
17 that addiction is a complex phenomenon and in the
18 case of Cabell County and the City of Huntington, I
19 think it's been driven, in part, by the large
20 oversupply of prescription opioids, so if you're
21 asking whether I think that we need to do a better
22 job of reducing the oversupply of prescription
23 opioids in order to help reduce the number of new
24 individuals developing opioid use disorder, I would

1 say absolutely.

2 But addiction is a life-long disease,
3 and people have opioid use disorder their whole
4 lives. That doesn't mean that they're living in
5 active addiction. But I just am -- am hesitant to
6 oversimplify and say that -- that closing or that
7 reducing the path to addiction is this single
8 thing.

9 We need to educate prescribers. We
10 need to educate the general public. We need to
11 reduce the oversupply of opioids. We need to do a
12 better job of using alternative treatments to treat
13 and manage pain. We need to do a better job of
14 linking people to care so that if people show up in
15 an emergency department with an overdose, they're
16 not simply given a dose of naloxone and sent home.

17 We need to screen adolescents and
18 teenagers in order to identify individuals that may
19 be using opioids nonmedically. So I apologize that
20 I'm not willing to just say, "Yes, I agree with the
21 president" or "No, I disagree with the president,"
22 but it's a complex process and a complex set of
23 solutions, and that's what I've articulated in my
24 report.

1 Q. Does anywhere in this sentence that I've
2 just read to you now two or three times -- is the
3 word "oversupply" anywhere in this sentence?

4 MR. BURNETT: Objection.

5 A. I mean, we've -- we've discussed --

6 Q. Doctor Alexander, it's a yes or no. The
7 sentence I just read to you two or three times, is
8 the word "oversupply" in that sentence?

9 MR. BURNETT: Counsel, he was in the
10 process of answering you. That's about the seventh
11 time you've interrupted him. Please do not do
12 that.

13 MS. GEIST: No, Doctor Alexander was
14 going off on another multi-paragraph answer, and
15 you, Counsel, directed me to be specific. I cannot
16 be more specific than I am being.

17 Q. The question is: Is the word "oversupply"
18 in this sentence that we're looking at?

19 MR. BURNETT: Counsel, what I'm
20 objecting to is he started to answer your question
21 and then you interrupted. He's entitled to answer
22 as he sees fit. If you don't like the answer, you
23 can ask a follow-up question.

24 MS. GEIST: He's not entitled to

1 engage --

2 MR. BURNETT: You are not entitled to
3 interrupt him.

4 MS. GEIST: I'm not entitled to have
5 my seven hours taken up by paragraph after
6 paragraph answer --

7 MR. BURNETT: Counsel, that is his
8 testimony. Whether or not you like it or not, he
9 is -- all -- everything that he's saying is on
10 topic. So it's all his testimony.

11 MS. GEIST: You know what, Counsel,
12 I'm reserving my right to extend, move the Court,
13 for an additional day of deposition from Doctor
14 Alexander if this keeps up. I'm warning you and
15 I'm providing notice to the witness.

16 I mean, I have seven hours. So we
17 will move the Court for relief and get additional
18 time in this case if Doctor Alexander will not
19 simply answer my questions.

20 MR. BURNETT: And Counsel, I think the
21 record will clearly show that he's trying to answer
22 your questions. Your questions are bad questions
23 and do not lend themselves to easy answers.

24 So you know, you're on notice that you

1 could be asking better questions that elicit, you
2 know, more fair responses.

3 BY MS. GEIST:

4 Q. So Doctor Alexander, let's try it again.
5 We've read this sentence now two or three times. I
6 assume your answer is the same, but I'll try it
7 again.

8 Can you agree or disagree with this
9 sentence: "Closing the path to addiction means
10 addressing the overprescription of legal opioids
11 and the proliferation of illicit opioids such as
12 heroin and drugs laced with fentanyl."

13 MR. BURNETT: Objection. Asked and
14 answered.

15 Q. Agree or disagree?

16 A. Well, I think we did discuss this
17 previously, and what I would say is that I would
18 prefer to look to my report which discusses in
19 detail my recommendations and my beliefs about what
20 needs to be done in Cabell County and the City of
21 Huntington.

22 Q. So you're not going to answer my question,
23 whether you can agree or disagree, correct?

24 MR. BURNETT: Objection, Counsel. He

1 has answered your question. The fact that he
2 doesn't answer it the way you like is irrelevant.
3 He answered your question several times.

4 MS. GEIST: No, he has not. But we're
5 going to -- we're going to move on, because I'm not
6 going to waste any more of my time.

7 And again, you're on notice that we
8 will seek relief from this deposition.

9 BY MS. GEIST:

10 Q. Now, Doctor Alexander, your first report
11 was in the Ohio case, as we discussed before. So
12 let's take a quick look at that, please. That is
13 Tab 32 or Exhibit 32, if you want to open up that
14 envelope.

15 ALEXANDER DEPOSITION EXHIBIT NO. 32

16 (G. Caleb Alexander, MD, MS, Expert
17 Witness Report, prepared for USDC,
18 Northern District of Ohio, MDL No.
19 2803 dated 3-24-19 was marked for
20 identification purposes as Alexander
21 Deposition Exhibit No. 32.)

22 VIDEO TECH: Tab 32 has been marked as
23 Exhibit 32.

24 MS. GEIST: Thank you, John.

1 A. Just -- I'm concerned I don't want to get
2 other tabs out of place. So it was Tab 5, this
3 report that we've just been considering, "From
4 Evidence to Impact"?

5 Q. I think you are correct. Yes. Yes, it is.

6 A. Okay. And Tab 4 is my overall report for
7 this case, I presume?

8 Q. Yes, it is.

9 A. Okay.

10 Q. And again just for the record, anytime it
11 is a tab, Tab 4 is Exhibit 4, we've marked it as
12 Exhibit 4. And your Johns Hopkins "Evidence to
13 Impact" report referenced in your expert report is
14 marked as Exhibit 5.

15 A. Okay. I've now opened Tab 32.

16 Q. Great. Do you have that in front of you,
17 Doctor?

18 A. Yes, I do.

19 Q. Okay. I lost you, so I assume you're
20 coming back.

21 A. Sorry. Yes, I do.

22 Q. That's okay. Okay. So can you just
23 identify for the record, please, what Exhibit 32
24 is?

1 A. It looks to be an expert witness report
2 that I produced.

3 Q. And you produced that in the Ohio
4 litigation? That was your first expert report
5 provided on behalf of plaintiffs in the opioids
6 litigation; is that correct?

7 A. Yes, ma'am.

8 Q. And that was in March 2019?

9 A. I would want to look at the dates, but I
10 don't have reason to believe otherwise.

11 Q. Okay. And in this first expert report, you
12 - as you are doing here - you are putting forward a
13 plan to address - or in your words - abate the
14 opioid -- the opioid epidemic, and you are
15 addressing the opioid epidemic in the two counties
16 in Ohio, Cuyahoga and Summit Counties. Is that
17 correct?

18 A. Yes, it is.

19 Q. Okay. And I assume that you -- you
20 endeavored to set forth a complete and comprehens
21 -- comprehensive plan that would be implemented as
22 appropriate by the specific community there in
23 Cuyahoga and Summit Counties?

24 A. Yes, I did.

1 Q. Okay. Now, if you look at your report here
2 from last year in the two counties in Ohio, it
3 contains sort of an outline of your -- your
4 categories of remedies that, from your perspective,
5 need to be undertaken to address the epidemic.

6 If you look on page 13 to 14, Doctor
7 Alexander --

8 A. Okay.

9 MR. BURNETT: Counsel, let me just
10 note here, as you noted before we started - or at
11 the start - the parties are on notice from the
12 Court that the questions in this deposition for
13 this case need to be focused on this case, so
14 you're now asking him his -- his -- you're asking
15 questions about his report in his prior case.

16 So, you know, I don't know how many
17 questions you're planning to ask on this, but you
18 know, just be mindful about that direction about
19 duplicative testimony.

20 MS. GEIST: I think you know I'm very
21 mindful of it. I was the one that raised at the
22 beginning, and I'm not asking him any substantive
23 questions about the different aspects of the
24 program he suggested or the programs and

1 interventions he suggested last year in the two
2 counties in Ohio.

3 Q. Doctor Alexander, you're with me on page 13
4 to 14 of this expert report from March 2019?

5 A. Yes, I am.

6 Q. Okay. And if you look on page 13, as you
7 indicated to me today, you note that you were
8 including a comprehensive set of abatement remedies
9 and that you "leave the task of defining the
10 specific application of these programs for Cuyahoga
11 and Summit Counties." You leave that to the
12 communities themselves.

13 Is that a fair characterization of
14 what you did?

15 A. Yes, it is.

16 Q. Okay. And if you look at page 14, here we
17 see --

18 MS. GEIST: If we could get to that
19 page, John, please.

20 Q. -- here we see your categories of remedies
21 or interventions or programs that from your
22 perspective need to be employed to abate or address
23 the opioid crisis. Is that correct?

24 A. Well, it seems to me that you're asking

1 about the substance of my abatement plan for
2 Cuyahoga and Summit Counties, but with that being
3 said, yes, these were the categories that I felt
4 were -- this was the way that I proposed to
5 structure the abatement plan for those communities.

6 Q. Okay. And you, in this case, have a
7 similar list of categories and subcategories in
8 terms of outlining your proposed abatement programs
9 and interventions. True?

10 MR. BURNETT: Objection.

11 A. I'm -- I have a -- I provide a list -- I
12 mean, I provide a structure for what I think the
13 community should consider, and so the way that I
14 have done so, we could review my report, but I do
15 provide an overarching framework.

16 I think without that, you know, it
17 would just be kind of mumbo-jumbo, so I do provide
18 a framework, yes.

19 Q. Yeah. Well, why don't you put side by
20 side, if you wouldn't mind, the report in this case
21 and then the report in Cuyahoga/Summit so we can
22 take a look at the categories.

23 And the categories in this case are on
24 page 15 of your expert report.

1 A. Okay.

2 Q. Do you have those two reports in front of
3 you, Doctor Alexander?

4 A. Yes, I do.

5 Q. Okay. If you look with me here under
6 Category 1 in the report that you've put in in this
7 case, Cabell County/Huntington, there's a section
8 entitled "Community Prevention and Resiliency." Do
9 you see that?

10 A. Yes, I do.

11 Q. That's a new category that you didn't have
12 in the Ohio county report, true?

13 A. Well, I'm not sure that I didn't speak to
14 it. Again, I feel that we're talking about that
15 we're talking about the substance of my earlier
16 report, but you know, it's an important matter to
17 -- I mean, the -- ultimately, communities are --
18 are getting the brunt of this.

19 So it's true that there's not a
20 specific call-out for it in my Cuyahoga and Summit
21 report, but I'm not sure that it's not,
22 nevertheless, featured within the report.

23 Q. Similarly, under Category 2, Treatment, if
24 you look at your report here, "Connecting

1 Individuals to Care," that is not an aspect of your
2 abatement or intervention plans for the two
3 counties in Ohio. True?

4 MR. BURNETT: Objection.

5 And again, as -- as the witness has
6 said himself, these questions go to the substance
7 of his prior report. I would suggest that you
8 focus on his current report, because you had the
9 opportunity to look at his prior report last year.

10 MS. GEIST: Well, we didn't have this
11 report last year when we asked him about his prior
12 report last year, so we're doing a comparison --

13 MR. BURNETT: But Counsel, your
14 question was asking him in the content of his last
15 year's prior if a certain topic was covered. That
16 would require him to look through his prior report
17 and, you know, and disprove a negative.

18 MR. RUBY: Counsel, this is Steve
19 Ruby. I was on the phone with Judge Wilkes when he
20 made the ruling that we've been referring to
21 earlier this week, and he was very clear that prior
22 reports and the like are the proper subject of
23 foundation questions to do things exactly like
24 this, to compare the content of those and ask

1 questions that are specific of this litigation.

2 So I'm -- I'm entirely comfortable
3 that that's the ruling that he'd make today. But
4 if we need to call him, we can.

5 MR. BURNETT: No, I don't think we
6 need to call him. I read the transcript. I wasn't
7 on the call. I read the transcript. I don't
8 recall him making that specific point that you're
9 saying.

10 I don't disagree that some questions
11 to compare to the current report could be okay, but
12 you know, the questions that you're asking,
13 Counsel, are -- require substantive discussion of
14 the past report.

15 MS. GEIST: So --

16 MR. FARRELL: This is Paul Farrell.
17 As co-lead of the MDL and lead trial counsel in
18 CT-2, I'm recommending, David, that what you do is
19 you contact Judge Wilkes and ask him to referee the
20 next hour or so of this deposition. That way we
21 can get some rulings.

22 I think it's probably best - both from
23 the defense standpoint and the plaintiffs'
24 standpoint - that we get more substantive questions

1 and answers than objections and argument from both
2 sides, and so while I tend to disagree with
3 Mr. Ruby, but I'm not interested in wasting any
4 more time with this.

5 Doctor Alexander is an important and
6 fundamental witness in this case, and this is an
7 opportunity for you to discover what he has to say,
8 and it seems like we're drifting afield into
9 impeachment and cross examination as if this was at
10 trial.

11 So David, why don't we take a
12 five-minute break. If Ms. Geist will agree, we'll
13 get special master on the phone, and he can call
14 balls and strikes.

15 MS. GEIST: I have -- I have
16 absolutely no problem getting the special master on
17 the phone. I reviewed the transcript myself. I
18 think exploring what is different here in the
19 abatement plan for Cabell County/Huntington that
20 was not included in an abatement plan put in in a
21 different jurisdiction, but a two-counties
22 jurisdiction last year, is quite an appropriate
23 line of questioning.

24 And so I'm not getting into questions

1 that were asked of Doctor Alexander whatsoever in
2 his prior deposition. I have -- I have absolutely
3 complied with the direction from Judge Wilkes as to
4 that point.

5 So these questions have nothing to do
6 with questions he was asked about before, and it
7 would be impossible, because there was no Cabell
8 County/Huntington report when he was asked
9 questions in the Ohio case.

10 MR. BURNETT: So Counsel, if you don't
11 object, I suggest we do what Mr. Farrell suggested
12 and get the Court on the phone.

13 I suppose the only alternative would
14 be if we can just focus on his current report,
15 perhaps that would be acceptable to everyone.

16 MS. GEIST: So I am trying to focus on
17 his current report, Counsel. That's exactly what
18 I'm doing. And my questions are, I think, pretty
19 obviously tied to the current report.

20 I am asking Doctor Alexander if he had
21 - as he testified - put in a comprehensive plan for
22 abatement last year, why does he have additional
23 categories for abatement here a year later in the
24 Cabell County/Huntington jurisdiction.

1 MR. BURNETT: Right, I understand your
2 position. I'm just saying that the only way to
3 possibly resolve this without the Court's
4 intervention would be if you -- if, you know, we
5 set aside the past report entirely and just asked
6 about the current report.

7 If not, I think there's enough of a
8 dispute here that, as Mr. Farrell said, we should
9 get the Court on the phone.

10 MS. GEIST: Well, first of all, I'm
11 going to ask my questions about why there were
12 categories of programs and interventions here in
13 this report that were not included in Track 1, in
14 Cuyahoga/Summit.

15 So we've -- we can take down the other
16 report. I've already marked it as an exhibit. And
17 if Doctor Alexander wants to just answer my
18 questions and the only report we have on the screen
19 in this report in this case, then I'm perfectly
20 fine too. But I am not going to agree to not ask
21 these questions.

22 MR. BURNETT: Right. Okay. In that
23 case, I think we should try to get the Court on the
24 phone. So as Mr. Farrell suggests, why don't we go

1 off the record and we can set up.

2 VIDEO OPERATOR: Time is 1:37, we are
3 off the record.

4 (A recess was taken after which the
5 proceedings continued as follows:)

6 VIDEO OPERATOR: The time is 1:55, we
7 are now back on the record.

8 MR. BURNETT: So Doctor Alexander,
9 while you were off, we had a discussion among
10 counsel, and the take-away is that in order to
11 hopefully avoid having to get Judge Wilkes on the
12 phone, we will endeavor to keep things moving, and
13 your role in that - to the extent you're able - is
14 to try and answer the question before you
15 succinctly, if possible; and if it requires a
16 longer answer, you know, answer as you see fit, but
17 with that recommendation.

18 THE DEPONENT: Of course. Thank you.
19 Thank you.

20 MS. GEIST: Okay.

21 BY MS. GEIST:

22 Q. Okay. So Doctor Alexander, do you have
23 your two reports still in front of you --

24 A. Yes, I --

1 Q. -- Exhibit 32, which is the Ohio report,
2 and Exhibit 4, which is your report in this case?

3 A. Yes, I do.

4 Q. Okay. Before we went off the record to
5 have a discussion, I was asking you about Category
6 1, Prevention, in your report in this case, and I
7 asked you --

8 MS. GEIST: Strike that.

9 Q. Under Category 1: Prevention, 1D, it's
10 entitled "Community Prevention and Resiliency." Do
11 you see that?

12 A. Yes, I do.

13 Q. And that is a new category here that you
14 did not have in the Ohio report; is that correct?

15 A. Well, it may be -- yes, it's correct that
16 it's a new category, but I'm not but it's not a new
17 concept. In other words, my guess is that in the
18 Ohio case, I consider this concept because it's an
19 important general concept in recovery.

20 Q. Do you know whether you considered it in
21 Ohio but didn't feel that it rose to the level of
22 having its own subheader?

23 A. Well, apparently I did not feel --
24 apparently I did not feel that it rose to that

1 level or that I needed to call it out to the same
2 degree in the Ohio report.

3 But I'm reporting that solely based on
4 seeing the Ohio report and seeing that I didn't do
5 so.

6 Q. Under Category 2, Treatment, you have a
7 number of subcategories under that category of
8 intervention or programming that you're suggesting.
9 Correct?

10 A. Yes.

11 Q. And your first category, "Connecting
12 Individuals to Care," do you see that?

13 A. Yes, I do.

14 Q. Is that new to this report that was not in
15 the Ohio report?

16 A. No, it is not. Again, it's a vital concept
17 and it's one that's reflected in the Ohio report as
18 well. Just not at the level of a category itself.

19 Q. So it -- it's -- you're telling me now it's
20 a vital concept, but it didn't have its own
21 subheader or separate discussion in the Ohio plan.
22 Is that accurate?

23 A. Again, without having the Ohio plan in
24 front of me and the opportunity to review it

1 carefully, I cannot answer that question.

2 Q. You do have the Ohio plan in front of you,
3 Doctor; we've marked it. And you're free to --
4 that's Exhibit 32.

5 A. Okay. I guess what I meant was that I
6 haven't asked for you to provide me the time to
7 review it. But I am confident that if we review it
8 together, there will be many instances where I
9 discuss the importance of connecting individuals to
10 care.

11 Q. But it didn't rise to its own separate
12 category or subheading. We can agree on that,
13 correct?

14 A. Yes, that's --

15 MR. BURNETT: Objection.

16 Q. Did you say "Yes"?

17 A. Yes, that's true.

18 Q. Now, under the same Category 2, Treatment,
19 there is a section here in your Cabell County/
20 Huntington report entitled "Workforce Expansion and
21 Resiliency." Do you see that?

22 A. Yes, I do.

23 Q. And then that was a new category of
24 intervention or programs here that was not included

1 in the Ohio report. Is that true?

2 A. Again, in each of these instances, it is
3 the case that these were not called out as separate
4 categories, but I wouldn't want to suggest that --
5 that they're not potentially important concepts
6 that are also incorporated into the earlier plan.

7 Q. And do you remember if you also used your
8 redress models document in the Ohio plan?

9 A. Well, it wasn't -- it's not one document,
10 but I believe that we did provide for -- again, it
11 would be helpful to have the opportunity to review
12 the Ohio plan if we're going to focus on it,
13 because it's been a while.

14 But I believe that I did provide some
15 similar epidemiologic estimates of populations in
16 that plan.

17 Q. And do you recall sitting here today if you
18 provided a separate estimate of the population that
19 would be able to use workplace -- workforce
20 expansion and resiliency, that program, in Ohio?

21 A. I do not recall, but my plan generally is
22 structured around these categories. So I -- my
23 estimates are conservative in many ways, and this
24 may reflect one of them.

1 In other words, it may have been in
2 Ohio that my estimates were conservative because I
3 didn't incorporate some of these additional costs
4 that we're considering -- considering now.

5 Q. Now, under Category 3, Recovery, do you see
6 where I am?

7 A. Yes, I do.

8 Q. There under 3C, there's a section entitled
9 "Vocational Training and Job Placement." Now, that
10 is a new category in Cabell County/Huntington,
11 correct?

12 MR. BURNETT: Objection.

13 A. Again, as -- again, as with my previous
14 answers on this matter, it may represent -- it does
15 represent a new category, but I don't think it
16 represents a new concept.

17 And one of the reasons that this --
18 that there's not -- and there are few reasons that
19 the categories don't exactly align between the last
20 report and this report. One of them is that we're
21 a year or two or three later; and another is that
22 we're in an entirely different part of the country
23 and that there are -- that the epidemic has played
24 out differently in different parts of the country.

1 So -- so we can explore this if it's
2 helpful in more detail, but I just want to help you
3 to understand why there's not sort of a one-to-one,
4 you know, well, you have 1, B and C here; why don't
5 you have 1A, B and C there?

6 Q. Under Category 3, Recovery, 3D, that's
7 "Reengineering the Workplace." Do you see that?

8 A. Yes, I do.

9 Q. And that too is a separate category for
10 Cabell County/Huntington. That was not in the Ohio
11 report, fair?

12 MR. BURNETT: Objection.

13 A. As a category, it wasn't called out in the
14 Ohio report, but the references or the -- the --
15 but I'm not suggesting that the Ohio report
16 entirely neglects or overlooks the importance of
17 the workplace, and I would want to review the
18 report more carefully with you in order to, you
19 know, reach firmer conclusions about that.

20 Q. Under this same Category 3, Recovery, 3E is
21 "Mental Health Counseling and Grief Support." Do
22 you see where I am?

23 A. Yes, I do.

24 Q. And that, too, is a new category here for

1 Cabell County/Huntington?

2 MR. BURNETT: Objection.

3 A. As with the previous queries, it may
4 represent a different category, but it's not a
5 concept that's foreign to any abatement plan,
6 because there's -- because this is an important,
7 you know, component of abating the epidemic.

8 Q. And then finally, your last category, 4,
9 here in Cabell County/Huntington, under 4D, there's
10 a subcategory, "Homeless and Housing Insecure
11 Individuals." Do you see that?

12 A. Yes, I do.

13 Q. Okay. And that is also a new category that
14 was not in the Ohio report, correct?

15 MR. BURNETT: Objection.

16 A. It may be a new category, but again, I do
17 not believe it's an entirely new concept.

18 Q. Now, you've said that to me a few times,
19 Doctor Alexander. So let me ask you a couple
20 questions about that. In this report, what you did
21 - as you explained to us earlier - is you have
22 proposed certain programs or interventions that you
23 believe should be put in place in Cabell County/
24 City of Huntington, correct?

1 A. Yes, ma'am.

2 Q. And then you took steps through your
3 redress model to provide population estimates and
4 also cost estimates for some of the programs or
5 interventions that you are suggesting. Correct?

6 A. Yes.

7 Q. Okay. And do you recall -- for each of
8 your programs and interventions proposed in Ohio,
9 do you recall providing a similar analysis? You
10 recommended the programs and the interventions, and
11 then through your redress model, you went through
12 each category, identified the population and
13 provided cost estimates for what you were really
14 talking about in terms of your abatement plan.

15 Fair?

16 MR. BURNETT: Objection.

17 A. I don't believe that my role was exactly
18 the same in the Ohio litigation and this
19 litigation.

20 Q. Okay. Can you -- can you open up the
21 folders or the envelopes for Tabs 33 and 34,
22 please?

23 MR. BURNETT: Are we setting these
24 aside, these documents?

1 ALEXANDER DEPOSITION EXHIBIT NOS. 33 AND 34

2 (G. Caleb Alexander, MD, MS,
3 Supplemental Expert Report - Update,
4 April 17, 2019 (MDL Ohio litigation)
5 and G. Caleb Alexander, MD, MS,
6 Supplemental Expert Report Update.
7 October 8, 2019 (MDL Ohio litigation)
8 was marked for identification purposes
9 as Alexander Deposition Exhibit Nos.
10 33 and 34.)

11 VIDEO TECH: My apologies, Melissa.

12 Did you say Tabs 34 and 35?

13 MS. GEIST: 33 and 34.

14 VIDEO TECH: Okay. Marking Tabs 33
15 and 34 as Exhibits 33 and 34.

16 A. I have those open.

17 Q. Do you have those, Doctor Alexander?

18 A. Yes, ma'am.

19 Q. Okay. And do you recognize these? They
20 appear, for the record, to be supplements to your
21 expert report in Ohio. Exhibit 33 is dated April
22 17th, 2019; and Exhibit 34 is dated October 8th,
23 2019. Do you see that?

24 A. Yes, ma'am.

1 Q. Okay. And do you see with respect to each
2 of your 15 categories for abatement plan -- plans
3 or interventions, you have here as part of your
4 redress model the population estimate and the cost
5 estimate for each of these. Do you see that?

6 A. Yes. But I believe that Professor Jeffrey
7 Liebman provided what I call - for lack of a better
8 word - micro estimates. In other words, that
9 Professor Liebman took the sorts of population
10 numbers that we developed and then -- and then
11 developed economic estimates based on that in a
12 manner not dissimilar to what George Barrett has
13 done.

14 I believe what we did in this instance
15 - and please keep in mind it's been a while since
16 I've looked at these materials - is that we used
17 national numbers and then scaled down projected
18 costs locally based on the relative rates of
19 overdose in Cuyahoga County and Summit County
20 relative to national levels.

21 So the process was a bit different,
22 but in both instances, our effort was to take a
23 population and derive some estimate of the costs of
24 abatement.

1 Q. Sure. And thank you for that explanation.
2 But you can see here in the redress model, there is
3 the an itemization of the population and there's
4 information relating to costs for each intervention
5 or proposed program, and the categories of
6 abatement or interventions that you're proposing
7 here in Cabell County/Huntington are not reflected
8 in the Ohio redress model, meaning there is no
9 section of the redress model talking about the
10 population or the cost that would be estimated for
11 the following programs and interventions that
12 you're proposing here.

13 So there's nothing indicating that you
14 considered as part of the abatement plan in Ohio
15 Community Prevention and Resiliency, Workforce
16 Expansion and Resiliency, Vocational Training and
17 Job Replacement, Reengineering the Workforce,
18 Mental Health Counseling and Grief Support,
19 Homeless and Housing Insecure Individuals.

20 All those categories here which you --
21 as we went through them, they're not highlighted as
22 subparts of your abatement plan in Ohio in any way.
23 And we agreed to that, correct?

24 MR. BURNETT: Counsel, I'm going to

1 object. You're not asking a question. You just
2 spoke your own paragraph or two testifying,
3 effectively, number one. And number two, the
4 documents you're asking him to look at is not the
5 redress report. One of them is a supplemental
6 expert report and another is a supplemental expert
7 report, so you need to clarify the terminology.

8 Q. Let's look at Exhibit 33, because it's
9 important to be precise here, I agree. So Exhibit
10 33 has a table on it, does it not?

11 A. Yes, it does.

12 Q. And it says, "Table 1 represents changes to
13 the redress models used to develop preliminary
14 estimates of the national abatement costs to
15 address the opioid epidemic."

16 And then it refers the reader to your
17 report to address the additional details. So the
18 redress categories -- while the entire redress
19 model is not here in Exhibit 33, each category is
20 set forth here in Table 1 and then again at Table 2
21 and it gets into costs.

22 Do you see that?

23 A. Yes, I do.

24 Q. Okay. And in Cabell County, Ohio {sic},

1 part of your proposed plan for abatement includes
2 Community Prevention and Resiliency, and that is
3 not a subcategory as part of the plan in Ohio and
4 that is also not here in any -- either of the
5 tables listing the redress categories. Correct?

6 MR. BURNETT: Objection.

7 A. We -- it -- we did not -- I did not call it
8 out separately to the best my knowledge, and based
9 on our brief review, as a separate category. But
10 again, I'm not suggesting that it's not potentially
11 important and that it's not covered elsewhere in my
12 Ohio report.

13 So I really want to underscore that
14 just because something like linking people to care
15 isn't necessarily called out with a banner heading
16 doesn't mean that it's not reflected in the content
17 and the substance of my report.

18 Q. It's not --

19 A. You are --

20 Q. It's not -- I'm sorry. Were you finished?

21 A. No, I was not.

22 Q. Please continue.

23 A. You are correct that I did not separately
24 itemize the costs for some categories in the Ohio

1 report that I do separately itemize the costs for
2 in Cabell County and the City of Huntington. And
3 if you'd like to discuss that, I'm happy to help
4 you understand why I did not do so in one instance,
5 but I did so in another.

6 Q. So on that point, you did not separately
7 categorize and put a cost to Community Prevention
8 and Resiliency in Ohio as you did in West Virginia,
9 Cabell County/Huntington, correct?

10 MR. BURNETT: Objection.

11 A. That's correct. But I'd like to also just
12 point out, these are national estimates, okay? So
13 if you look at page 3 of -- I believe the Exhibit
14 33, Tab 33, if you look at Table -- yeah, Table --
15 I'm sorry, Table 2. It's being projected.

16 So these are -- these are national
17 estimates, and Professor Liebman, Jeffrey Liebman,
18 performed an entirely different -- produced a
19 separate report and used micro estimates, and he
20 may or may not have included community-based
21 programs.

22 But it is the case that in these
23 preliminary estimates of abatement costs,
24 nationally that I produced for Cuyahoga and Summit

1 Counties 18 or 24 months ago that I did not have a
2 separate call-out category for community resilience
3 and community prevention programs.

4 Q. And similarly, the same answer would be for
5 connecting individuals to care. That is a separate
6 part of your abatement plan here in Cabell County/
7 Huntington and there's not a separate line item or
8 discussion or cost estimate relating to connecting
9 individuals to care. Would you agree with me on
10 that?

11 A. I would --

12 MR. BURNETT: Objection.

13 A. -- although it may be subsumed within some
14 of these abatement categories in the Ohio report.
15 So for example, some of the linkages that happened
16 in connecting people to care happened through
17 emergency departments, and this report in Ohio does
18 include interventions to help improve quality of
19 care for people that are seen in emergency
20 departments.

21 And --

22 Q. Sure. And so does the report in Cabell
23 County/Huntington, right?

24 MR. BURNETT: Hold on, Counsel. He

1 wasn't finished. You interrupted him again.

2 A. Well, my point is that I could give other
3 examples of where some of the concepts that are
4 called out and elevated to the level of a subheader
5 in West Virginia may -- are nevertheless present
6 and embedded in different abatement categories in
7 Ohio.

8 And so while it may be that they're
9 not elevated and called out at the -- at the level
10 of a header, they are, nevertheless, may be
11 subsumed within some of these 15 categories that
12 we're looking at in Table 2.

13 Q. There's also not a separate cost estimate
14 for Community Prevention and Resiliency in Ohio as
15 there is in Cabell County/Huntington, true?

16 MR. BURNETT: Objection.

17 A. I believe that's the case.

18 Q. I'm sorry, Doctor Alexander?

19 A. I believe that's true.

20 Q. And same thing for Connecting Individuals
21 to Care? That's a separate header and a separate
22 cost estimate for Cabell County/Huntington and that
23 is not the case for your Ohio report, correct?

24 MR. BURNETT: Objection.

1 A. Yes, it's not a separate header, but these
2 reports are not -- they're not identical reports.
3 I mean, they're two different communities and the
4 reports take place at two different points in time,
5 and whether or not something is a header or not
6 doesn't mean that it's not considered or
7 incorporated into the -- the concepts and the plan
8 as I have put forth.

9 So it's hard to talk about an
10 abstract, but I hope that that point is clear.

11 Q. Connecting Individuals to Care is on a
12 separate cost item in Ohio, as it is here in Cabell
13 County/Huntington, correct?

14 MR. BURNETT: Objection.

15 A. Correct. It's not a separate line item,
16 but it may be subsumed in some of these other
17 categories.

18 Q. Workforce Expansion and Resiliency, again,
19 that is not a separate cost estimate in Ohio as it
20 is here in Cabell County/Huntington. True?

21 MR. BURNETT: Objection.

22 A. Again, it hasn't been broken out as a
23 separate category, but it may be subsumed to some
24 degree in some of these categories that are

1 depicted.

2 Q. Same question with respect to Vocational
3 Training and Job Placement. That is not a separate
4 cost estimate here in Cabell County/Huntington --

5 MS. GEIST: I'm sorry, strike that.

6 Q. Same question with respect to Vocational
7 Training and Job Placement. That is not a separate
8 cost estimate in the Ohio report, but it is a
9 separate cost estimate in Cabell County/Ohio, true?

10 MR. BURNETT: Objection.

11 A. Yes, it may be subsumed within some of the
12 other categories and interventions in the Ohio
13 setting, but it was not called out as a separate
14 line item.

15 Q. Same question with respect to Reengineering
16 the Workplace. Reengineering the Workplace is a
17 separate cost estimate here in Cabell County/
18 Huntington and was not a separate cost estimate in
19 your Ohio abatement report. True?

20 MR. BURNETT: Objection.

21 A. Again, it may be subsumed to some degree in
22 some of the other categories, but you're correct
23 that it's not a separate called-out category.

24 Q. Same question with respect to Mental Health

1 Counseling and Grief Support. Again, that is a
2 separate subheader in your abatement plan here in
3 Cabell County/Huntington; it is a separate cost
4 estimate, a separate line item, and that was not
5 included in your Ohio report?

6 There's no separate cost estimate for
7 Mental Health Counseling and Grief Support.
8 Correct?

9 MR. BURNETT: Objection.

10 A. I mean, the reports are not identical, and
11 there are concepts that -- there are many, many
12 shared elements and shared concepts, and it's also
13 worth noting that my understanding from looking at
14 the economic estimates - although it's not what I
15 focused on - is that the vast majority of costs are
16 treatment, and that's sort of staring -- staring us
17 right -- you know, front and center.

18 But -- but the reports are not -- so I
19 guess my point is that the underlying concepts,
20 that there's a lot that's shared, but the -- the
21 called-out categories are not identical between the
22 reports.

23 Q. So the answer to my question is that I am
24 correct, there is not a separate cost estimate or

1 line item for Mental Health Counseling and Grief
2 Support in the Ohio report like there is here in
3 Cabell County/Huntington. Am I correct about that?

4 MR. BURNETT: Objection.

5 A. It is -- it is true that there's not a
6 separate line item. But some of those services and
7 some of those costs may be subsumed in other
8 categories that are represented in Table 2 that's
9 depicted on the left of the screen currently.

10 Q. Same question with respect to Homeless and
11 Housing Insecure Individuals. That is a separate
12 component of the abatement plan here for Cabell
13 County/Huntington; it has a separate cost estimate
14 associated with that.

15 And that is not a separate part of the
16 plan and does not have a separate dollar figure or
17 cost estimate associated with it in Ohio. True?

18 MR. BURNETT: Objection.

19 A. I mean, this is an important matter, as
20 many of the others are that we've discussed, when
21 thinking about abatement. I haven't had the chance
22 to review my Ohio report in detail in preparation
23 for this deposition. I wasn't anticipating that we
24 would be examining it in -- in this level of

1 detail.

2 But I would be surprised if there's
3 not a consideration within the report of
4 homelessness and housing insecurity and the
5 important role that that plays for some individuals
6 with opioid use disorder in preventing their --
7 their treatment and recovery.

8 Q. Would you agree with me that there is not a
9 separate cost estimate or line item in your
10 abatement plan for Ohio for Homeless and Housing
11 Insecure Individuals as there is here in Cabell
12 County/Huntington?

13 MR. BURNETT: Objection.

14 A. I'm just looking at Exhibit -- Tab 4, and
15 I'd just like to see, again, the -- the categories.

16 So yes, Housing and Homeless
17 Insecurity as a concept is an important one, and my
18 guess is that it is included or noted in my Ohio
19 report but may not be called out - or is not called
20 out - as a separate line item.

21 Q. Now, Doctor Alexander, in the Cabell
22 County/Huntington abatement plan that you have
23 suggested for the county and the city within the
24 county, your abatement plan stretches through 15

1 years. Is that accurate?

2 A. Yes, it is.

3 Q. And I believe you state in your report that
4 some abatement approaches may be framed in the
5 context of looking forward 10 or 15 years, and you
6 are opining that your plan should extend out all
7 the way to 15 years, the high end of that estimate.
8 Is that correct?

9 A. I do propose a 15-year plan, but I -- there
10 are -- the legacy of the opioid epidemic is going
11 to be with Cabell County and the City of Huntington
12 far longer than that.

13 Q. You proposed that the abatement plan to be
14 put forward in Ohio, if that were to be ordered,
15 would only go out ten years. So five years less
16 than what you're proposing here in Cabell
17 County/Huntington. Is that correct?

18 A. I would have to -- I mean, the -- the
19 materials that I'm seeing in front of me say "10
20 years," but I would want to review the report more
21 carefully to be sure if there was any consideration
22 of 15 versus 10 years.

23 Q. Well, you have your report from Ohio in
24 front of you, and again, I'm mindful of the ruling.

1 I'm not asking you substantive questions about it,
2 but I am asking you to confirm for us today that
3 your proposed abatement plan in Ohio is for
4 interventions and programs that would occur or be
5 implemented over a 10-year-period. And of course,
6 there's a cost associated with that, correct?

7 A. Yes.

8 Q. Okay. And here, in Cabell County/
9 Huntington, you are suggest that the abatement plan
10 that you are proposing be implemented here stretch
11 out an additional five years. Not 10 years, but
12 15. Is that correct?

13 MR. BURNETT: Hold on, Counsel. Your
14 prior question was two questions in one and it's
15 not clear which question the witness was answering.

16 MS. GEIST: Do you have an objection
17 to form?

18 MR. BURNETT: I do.

19 Q. Can you answer my question, Doctor
20 Alexander?

21 A. What specifically was the question?

22 Q. All right. Here's the question really
23 simple: When you did your Ohio report, you put in
24 an abatement report, correct?

1 A. Yes.

2 Q. You suggested programs and interventions
3 for certain categories and for certain population,
4 true?

5 A. Yes.

6 Q. And you put cost estimates or dollar
7 figures associated with the implementation of those
8 programs. Correct?

9 A. Yes.

10 Q. Okay. And your plan called for those
11 programs to go, be implemented for 10 years. True?

12 A. Well, the documents in front of me - which
13 represent two addendum to probably a 100-page
14 report - both suggest economic estimates of 10
15 years, but I guess I would like to see the report
16 if we're dis -- if we are exploring how I reasoned
17 through the length of abatement.

18 And my guess is there is commentary
19 within the report putting some context and meat on
20 the bone around that specific target of 10 years.
21 So I just have a little bit of concern about
22 oversimplifying, you know, my opinions in the last
23 case regarding how long I think abatement will take
24 or how long an abatement plan is necessary for.

1 Q. So looking here at these documents we have
2 on the screen, these are supplements to your Ohio
3 report, Exhibits 33 and 34. Correct?

4 A. Yes.

5 Q. And they talk about a 10-year cost. You
6 see that on both of these pages that we're looking
7 at together?

8 A. Yes, I do.

9 Q. Okay. But you want to take a look at your
10 report and see whether you talked about a different
11 time frame for your abatement plan in Ohio?

12 MR. BURNETT: Objection.

13 A. No, I would like to see -- if it's
14 important -- if this matter is important, I would
15 like to see my Ohio report so that I can review the
16 section of the report where I discussed how long I
17 think abatement will be required for.

18 Because my -- because there's --
19 there's nuance there, and I just would like to see
20 my words if we're -- if we're focusing on what my
21 words were at one point in time, I'd like to see
22 those words.

23 Q. So sure, and I'm happy to have you do that.
24 We marked your Ohio report as Exhibit 32. The

1 supplements that you provided in that case have
2 been marked as Exhibits 33 and 34. And in your
3 Ohio report, you reference some abatement
4 approaches may be framed in the context of looking
5 forward five or ten years, and you chose the higher
6 end, the 10-year plan, for Ohio.

7 And if you want to look at your report
8 and confirm that for me, I'm happy for you to do
9 that.

10 A. Thank you.

11 MR. BURNETT: Counsel, this does go
12 into the issue of duplicative testimony. This is
13 -- his reasoning for why he may have included ten
14 years in the prior report could have been covered
15 in the prior deposition.

16 I really think this gets into the
17 issue we were talking about where you really need
18 to focus on this report, and you know, right now,
19 you're asking him to review the substance of his
20 prior report.

21 MS. GEIST: All I really want, Counsel
22 - as you know; which should be clear from my
23 questions - is just a confirmation that the
24 abatement plan in Ohio for the two counties there,

1 that the plan proposed by Doctor Alexander in that
2 jurisdiction was a 10-year plan. That's it.

3 MR. BURNETT: And Counsel, he answered
4 that with regard to 33 and 34 and the excerpts that
5 we just had highlighted here. So I think he's
6 answered that, and I think we should just move on.

7 MS. GEIST: Well, what I heard from
8 the witness was he was not 100 percent comfortable
9 in agreeing that he had a 10-year plan in Ohio and
10 he would like to look at his report.

11 So I'm offering him the opportunity to
12 look at his report and confirm that the plan
13 proposed in Ohio, the abatement plan there for the
14 two counties, was a 10-year plan.

15 A. Yeah, thank you for that. And I did read
16 Paragraph 30 from my Ohio report, and it's very
17 helpful, and I think it -- I think it illustrates
18 some of this nuance that I referred to. So I won't
19 read it or call it out further, but I just want to
20 underscore that I think it provides some of the
21 context.

22 I am comfortable now confirming that
23 this -- that the economic or epidemiologic
24 estimates that I provided in Ohio were for ten

1 years.

2 Q. Thank you. And here in Cabell County/
3 Huntington, your proposal for your abatement plan
4 -- should the plan or any aspect of the plan be
5 ordered by the Court, is for 15 years, for the
6 county -- Cabell County, excuse me, and the City of
7 Huntington. I'm correct about that?

8 A. Sorry. Can you please repeat the question?

9 Q. Sure. Here in Cabell County/Huntington- we
10 have one county and the city within the county -
11 your abatement plan that you're proposing, you are
12 proposing a 15-year abatement plan. Correct?

13 A. Yes, I mean, that's -- yes. Yes.

14 MS. GEIST: Okay. Is it a good time
15 now to take a break?

16 MR. BURNETT: Sure. Ten minutes.

17 VIDEO OPERATOR: The time is 2:29, we
18 are now going off the record.

19 (A recess was taken after which the
20 proceedings continued as follows:)

21 VIDEO OPERATOR: The time is 2:42. We
22 are now back on the record.

23 BY MS. GEIST:

24 Q. Doctor Alexander, you engaged in some

1 meetings or interviews or phone calls with
2 individuals who are part of the Cabell
3 County/Huntington community; is that right?

4 I think you're on mute.

5 MR. BURNETT: You're muted.

6 A. Thank you, I apologize. Yes, I did.

7 Q. And if we look at page 6 of your report,
8 you reference that either you or some of your "team
9 members" "have spoken with many local stakeholders"
10 And when you say "team members," are you referring
11 to individuals at Monument Analytics?

12 A. Yes, I am.

13 Q. Okay. And are those individuals other than
14 the two individuals you mentioned to me earlier in
15 this deposition?

16 A. They would --

17 Q. I confess I forget their names. I
18 apologize.

19 A. No, no, that's fine. Mr. Mansour and
20 Ms. Ozenberger, and they would represent -- it's
21 possible that another team member, Elena Fernandez,
22 E-L-E-N-A, Fernandez, may have participated in one
23 or two calls. But Mr. Mansour and Ms. Ozenberger
24 were the primary Monument Analytics team members

1 that would have participated in these calls.

2 Q. And looking at the list of individuals that
3 appear on page 6 of your report, is this a complete
4 list of individuals that either you or your team
5 members spoke with in connection with forming your
6 opinions in the case?

7 A. Yes, I believe so.

8 Q. And were these all individual telephone
9 calls?

10 A. As opposed to? What would be the
11 alternative?

12 Q. Did you have any in-person meetings?

13 A. No, I did not. I had wanted to visit
14 Cabell County and the City of Huntington and
15 unfortunately, because of the pandemic, I did not
16 do so. I had gone as far as having dates picked
17 out when I was to visit, and that visit was called
18 off.

19 Q. Okay. So all of the -- whether it was you
20 or somebody at Monument Analytics, all of the
21 individuals on page 6, you spoke with by phone,
22 correct?

23 A. I believe Mr. Mansour traveled to Cabell
24 County and the City - in fact, I'm sure that he did

1 - and so he was present for several face-to-face
2 meetings, but I was not.

3 Q. And do you know who Mr. Mansour met with
4 face to face from this list?

5 A. I do not know for sure. I know that he was
6 present for a day or two days of meetings and he
7 related that he met with a comprehensive, you know,
8 set of individuals, so my sense is that he had an
9 opportunity to meet broadly with many, many
10 affected stakeholders.

11 Q. Did anybody else other than Mr. Mansour
12 meet with individuals in Cabell County in person?

13 A. No one else from Monument Analytics, no.

14 Q. And do you know when Mr. Mansour went to
15 Cabell County to have these meetings?

16 A. I do not, but those -- there were
17 plaintiffs that were present, and I'm sure that
18 that information could be provided were it to be
19 important and helpful.

20 Q. When you say there were plaintiffs present,
21 are you referring to the plaintiffs' counsel at
22 these meetings?

23 A. I am sorry, I'm revealing my lack of
24 familiarity with the -- with the field. So yes,

1 there were plaintiffs' counsel present.

2 Q. I see. Okay. Now, did you personally have
3 phone conversations with any of the individuals
4 listed on page 6?

5 A. Yes, I did.

6 Q. Okay. And can you identify for me which
7 individuals you had a phone call or calls with?

8 A. I cannot do so with full confidence. I can
9 tell you that I had one call that was with a number
10 of people involved in the educational system.

11 I had a second call with Doctor
12 Kilkenny and colleagues, so individuals
13 representing public health officers, among others.

14 I was on another call and had another
15 call that included, I believe, perhaps some of
16 those same individuals, but also law enforcement
17 representatives.

18 But I cannot -- other than the notes
19 that I've provided - that I understand that you
20 have - I don't have a precise record of the
21 participants in any particular call.

22 Q. And did you have calls where it was more
23 than just you and one of these individuals from
24 Cabell County? In other words, was it a conference

1 call with a number of people on the phone?

2 A. In all cases, yes.

3 Q. Okay. And was plaintiffs' counsel,
4 plaintiffs' lawyers representing Cabell County/City
5 of Huntington, were they also on these phone calls?

6 A. I -- it would be hard for me to imagine
7 that they weren't, so I believe that they would
8 always have been present, yes.

9 Q. Now, if you'd take a look at Exhibit 52 --
10 do you have that in front of you, Doctor?

11 A. One minute, please.

12 Q. Uh-huh.

13 ALEXANDER DEPOSITION EXHIBIT NO. 52

14 (Alexander notes taken from telephonic
15 meetings with people within Cabell
16 County/City of Huntington was marked
17 for identification purposes as
18 Alexander Deposition Exhibit No. 52.)

19 A. Yes, I do.

20 Q. Okay. And Exhibit 52 was provided to us by
21 plaintiffs' counsel. Can you identify them for --
22 for me and for the record, please?

23 A. Identify them?

24 Q. Yeah. So tell me, what is Exhibit 52? I'm

1 looking at it.

2 A. Oh, I see. I thought you were -- I --
3 sorry. I thought you were asking me to identify
4 people.

5 Exhibit 2 {sic} represents notes that
6 I took based on, I believe, two different
7 conversations that I had.

8 Q. Okay. So these are -- these are your own
9 personal notes that we've marked as Exhibit 52; is
10 that right?

11 A. Yes, ma'am.

12 Q. And do you know why there are blackouts or
13 redactions made in these notes?

14 A. I believe information was redacted because
15 it was felt to be privileged. But you would have
16 to ask the counsel to be sure. It was not
17 something that I blacked out myself.

18 Q. Okay.

19 MS. GEIST: And I'll just make a
20 request at this time to counsel to identify whether
21 the redactions were made from counsel representing
22 Cabell County or Huntington and the reason for the
23 redactions.

24 MR. BURNETT: Yes --

1 MS. GEIST: Obviously we can take care
2 of this after the deposition, but I think we had a
3 request in regarding these redactions, and I'm not
4 aware of a response. So are these redacted for
5 privilege or can you tell me why they were redacted
6 now?

7 MR. BURNETT: They were redacted for,
8 you know, for privilege and/or work product and/or
9 any other protection.

10 I do recall that there was a request
11 for information about that and I -- I'm not sure
12 whether there was a response or not.

13 MS. GEIST: I'm not aware of a
14 response, so I'll just note for the record we're
15 still looking for a response, whether that's a
16 privilege log or some letter or some communication
17 from counsel as to the reason for the redactions,
18 would be great.

19 Thank you.

20 BY MS. GEIST:

21 Q. Now, Doctor Alexander, did your colleagues
22 from Monument Analytics also take notes when they
23 met with -- met with in person or spoke with the
24 individuals listed on page 6 of your report?

1 A. I don't know.

2 Q. And that was Mr. Mansour, Ms. Ozenberger
3 and Elana -- I'm sorry, Elana --

4 A. Fernandez, Fernandez.

5 Q. Okay.

6 MS. GEIST: I'll just put a formal
7 request on the record that any notes taken by these
8 three individuals from Monument Analytics during
9 their in-person or telephone meetings with
10 individuals at Cabell County be produced to us,
11 please.

12 MR. BURNETT: I note the request.

13 Q. Now, did the -- did the interviews and
14 meetings that you had with individuals from Cabell
15 County/Huntington, Doctor Alexander, inform your
16 opinions in this case in any way?

17 A. Definitely.

18 Q. And when did you conduct these phone
19 conferences that you had? Do you remember how soon
20 before your expert report was served in this case?

21 A. I apologize, but I do not. I do not. I
22 mean, I think that they took place over the course
23 of six to nine months, and I don't know the precise
24 dates. But they weren't within the last, you know,

1 two weeks before I submitted the report; and they
2 weren't two years ago.

3 So I can give you a window, but I'm
4 sorry that I don't have more precise dates.

5 Q. Okay. You can set those -- you can set
6 Exhibit 52 aside for now.

7 Doctor Alexander, I'm going to turn in
8 a minute to the actual programs and interventions
9 that you've proposed in your plan. Hopefully we
10 can get through those quickly since time is running
11 out. But before we get to that, you reference The
12 City of Solutions document in your expert report.
13 Do you recall that document?

14 A. Yes, I do.

15 Q. Okay. Do you want to go ahead and open up
16 Envelope or Tab 8, please?

17 VIDEO TECH: Tab 8 has been marked as
18 Exhibit 8.

19 ALEXANDER DEPOSITION EXHIBIT NO. 8

20 ("The City of Solutions Huntington, WV
21 - A Guide to What Works (and what does
22 not) in Reducing the Impact of
23 Substance Use on Local Communities"
24 dated September 2019

1 (HUNT_00365846-6015) was marked for
2 identification purposes as Alexander
3 Deposition Exhibit No. 8.)

4 A. Okay, I have it open.

5 Q. Great. Now, looking at Exhibit 8, would
6 you agree with me that this is a very comprehensive
7 and extensive plan that was put in place by the
8 City of Huntington? It's entitled "A Guide to What
9 Works (and what does not) in Reducing the Impact of
10 Substance Use on Local Communities" dated September
11 2019.

12 A. I mean, I would -- I think it's a helpful
13 plan that sets forth many very evidence-based and
14 reasonable abatement measures.

15 Q. Now, when you go through the plan --

16 MS. GEIST: Actually, strike that.

17 Q. When you look at "The City of Solutions: A
18 Guide to What Works (and what does not)," it sets
19 forth in various categories what the community has
20 done, what they have now, where they are going, and
21 a little bit of the history of substance use
22 disorder and drug problems in the region. Is that
23 fair?

24 A. Yes, I believe so. It's been a while since

1 I looked carefully at the plan, but I think that --
2 but I believe that's the case.

3 Q. Okay. Do you know when Cabell County/City
4 of Huntington put in place their plan to address
5 substance use disorder and opioid use disorder in
6 the community?

7 A. Well, I think -- I mean, there is this
8 document, but there is a large number of activities
9 that have taken place over many years, so it's hard
10 to identify one specific point.

11 Are you asking if I know when this
12 plan was issued?

13 Q. Well, let me ask it a different way. Did
14 you review the Strategic Plans that were put in
15 place by the Mayor of Huntington Office of Drug
16 Control Policy beginning in 2015?

17 A. Yes, I did, among -- among dozens or a
18 hundred or more other produced materials about the
19 community. Yes, I did.

20 Q. Sure. But you would agree with me that
21 this area of the country, Cabell County/City of
22 Huntington has been addressing -- implementing and
23 developing programs since at least as early as
24 2015. Is that fair?

1 MR. BURNETT: Objection.

2 A. Yes, I believe that's fair.

3 Q. Do you think that some of the programs to
4 address opioid use disorder and substance use
5 disorder put in place in this community could be
6 useful models for other communities in the United
7 States dealing with substance use disorder?

8 A. Sure. I mean, I think we can all learn
9 from each other. This is -- we're not alone here.
10 There's no community that hasn't been touched one
11 way or another, so I think there's a lot to learn
12 from other communities. Yes.

13 Q. Now, this is a fairly long, comprehensive
14 document that we're looking at together now.
15 Correct?

16 A. Well, I mean, I would agree that it's long.
17 I think comprehensive is -- are your words, and I
18 guess I would -- I think it's a helpful -- you
19 know, I think it's a helpful -- it's a helpful plan
20 that describes many evidence-based and evidence-
21 informed abatement measures.

22 Q. You consider yourself to be an expert, I
23 assume, on plans to address substance use disorder,
24 opioid use disorder, across the United States. Is

1 that correct?

2 A. Well, my expertise is -- is -- as an
3 epidemiologist, has focused extensively on
4 identifying and assessing evidence-based methods to
5 reverse overdoses and other opioid-related harms,
6 yes.

7 Q. Has Cabell County/City of Huntington done
8 an excellent job in addressing the opioid use
9 disorder or substance use disorder crisis in the
10 community?

11 MR. BURNETT: Objection, outside the
12 scope.

13 A. I wasn't asked to -- and I think that from
14 my experience, speaking with local stakeholders and
15 reviewing the materials that I've reviewed, what
16 I've seen is a community that's been ravaged and
17 torn apart, and I think been individuals have shown
18 remarkable leadership and remarkable resilience.

19 You know, am I able to identify areas
20 where - resources notwithstanding - they might have
21 done better? I suppose so. But I don't think that
22 -- I mean, I looked carefully in my plan at the --
23 what's been done to date, but I did -- was not
24 asked - nor do I feel that it's my position - to

1 sort of give them a grade on how they've done over
2 the past few years.

3 Q. You don't have -- sitting here today, you
4 don't have any opinions that they have been
5 deficient in any way in terms of the
6 implementations they have done to date. Is that
7 true?

8 MR. BURNETT: Objection.

9 A. Do you mean in a legal sense do I have
10 opinions, or just in an informal colloquial sense?

11 Q. No, I mean like, do you have any criticisms
12 of the implementations and the programs that Cabell
13 County/City of Huntington have put in place since
14 2015?

15 A. Well, I --

16 MR. BURNETT: Objection.

17 A. Yeah, I was asked to look forward, not look
18 backwards, and I did not conduct any comprehensive
19 sort of program evaluation of the performance of
20 the interventions to date.

21 I think many have been quite laudable,
22 such as Project Engage, which has sought to better
23 link people seen in clinical settings with opioid
24 use disorder with treatment; programs such as

1 Lily's Place or the MARC and the MOMS program for
2 women that have addiction and are pregnant, so
3 they're --

4 The syringe services program, which I
5 believe is one of the first in the state and has
6 really stood apart from many others in terms of
7 their ability to conduct outreach.

8 So I think that there are many
9 laudable undertakings that the community has --
10 performed, but certainly I can identify some areas
11 where I think that - with resources notwithstanding
12 - that they might have done more, yes.

13 Q. Now, you note in your report on page 11
14 that "the Community has" "mobilized in many ways to
15 address the challenges head-on," and you had list
16 some of the programs that you just mentioned to me
17 just now, such as Project Engage, PROACT, etc.

18 And then you also talk in terms of the
19 "remarkable transformation in the Community's
20 system of care to manage OUD among expectant
21 mothers and their offspring."

22 MR. BURNETT: Counsel, where -- where
23 on page 11 are you quoting from?

24 MS. GEIST: I'm in the middle of page

1 11.

2 MR. BURNETT: What paragraph?

3 MS. GEIST: 26 and 27.

4 Q. And you also agree, don't you, Doctor
5 Alexander, that Cabell County/Huntington engaged in
6 very early initiatives through Mayor Williams'
7 Office of Drug Control Policy to timely and
8 comprehensively recognize the need for data for
9 early intervention? You agree with that, don't
10 you?

11 MR. BURNETT: Where is that?

12 A. Are those my words, or not?

13 Q. I'm not making them up. These are your
14 words from your report.

15 A. But where --

16 MR. BURNETT: Counsel, if you're
17 asking him about specific language, please point us
18 to it.

19 Q. I'm asking you if you -- if you agree with
20 what I just said. Do you agree --

21 A. But I --

22 Q. -- that Cabell County -- Cabell County/
23 Huntington, through early initiatives of Mayor
24 Williams' Office of Drug Control Policy timely

1 recognized the need for comprehensive data for
2 early intervention?

3 MR. BURNETT: Counsel, same request.
4 Where are you quoting this from?

5 MS. GEIST: I'm asking him the
6 question.

7 A. But I don't see in Paragraph 27 or 28 any
8 mention of Mayor Williams. I may be missing it,
9 but if you could just point out to me where I
10 mention Mayor Williams.

11 Q. You can't agree with my -- my question
12 without me showing you the exact --

13 MR. BURNETT: Counsel, you're -- now
14 you're asking him a memory test. You are quoting
15 from his report, clearly, but you're not telling us
16 where you're quoting from. That's not fair.

17 MS. GEIST: I'm asking him if he
18 agrees.

19 MR. BURNETT: You're asking him if he
20 agrees on specific language that you are reading
21 without telling us what you are reading.

22 MS. GEIST: I'm reading from my own
23 notes. I'm not reading from the report. I'll ask
24 it this way:

1 Q. Do you agree that this community, through
2 the Mayor's Office of Drug Control Policy, engaged
3 in early initiatives to address the opioid use
4 disorder -- to address opioid use disorder or
5 substance use disorder in the community? Do you
6 agree with that?

7 A. Would it be possible to show Tab 4 and to
8 show where you're reading from in my report?

9 Q. So I'm not reading from your report.

10 A. Okay.

11 Q. Do you have your report in front of you?

12 A. I do. I'm sorry if I misunderstood. I
13 thought that you read a sentence and it referred to
14 Mayor Williams and early initiatives and that you
15 had suggested that it was either in Paragraph 27 or
16 28 of my report, and I just am not seeing any
17 mention or callout of Mayor Williams in those
18 paragraphs.

19 And the language sounded a little bit
20 foreign to me. I'm not suggesting that I disagree
21 with the sentence or the claim. It's just I want
22 to be clear, is it -- is it your words or is it my
23 words? And if it is indeed in my report, I just am
24 asking to see where I called out Mayor Williams in

1 my report by name.

2 Q. All I'm asking is if you agree with this
3 sentence -- but if you can't answer me "yes" or
4 "no," let's just move on.

5 A. No, no, I'm sorry --

6 MR. BURNETT: Counsel --

7 Q. No, I'm just going to move on. This is
8 wasting my time. I'm just going to move on.

9 A. Okay.

10 Q. Now, back to The City of Solutions
11 document --

12 A. Yeah.

13 Q. -- do you agree with me, Doctor Alexander,
14 that in terms of the programs that are listed in
15 the document, that this is only a partial list of
16 the programs available to Cabell/Huntington --
17 Cabell County/Huntington now?

18 MR. BURNETT: Objection.

19 A. I would guess that that is the case, but I
20 would want to examine further, but if this is a
21 document that was on the ground, you know, two or
22 three years ago, then I would think it's all but
23 certain that newer programs have originated and
24 spawned, if you will, since this report was issued.

1 Q. So let's take a look at page 15 of The City
2 of Solutions guidebook. Are you there with me,
3 Doctor Alexander?

4 A. Yes, ma'am.

5 Q. Okay. And this section of the guidebook is
6 titled "Prevention and Early Intervention." Do you
7 see that?

8 A. Yes, ma'am.

9 Q. Okay. And this begins a discussion of the
10 interventions and programs that have been put in
11 place by the community to address the opioid use
12 disorder or opioid epidemic in the area. Do you
13 see that?

14 A. Yes, I do.

15 Q. Okay. And so your Category 1 of your
16 abatement plan is entitled, as we know, "PREVENTION
17 - REDUCING OPIOID OVERSUPPLY AND IMPROVING SAFE
18 OPIOID USE" and it talks about early intervention.
19 And that's what we have as well here in The City of
20 Solutions guidebook. Is that fair?

21 A. I don't know, and I would be very surprised
22 if the content is perfectly aligned. But I -- if
23 you're asking whether both The City of Solutions,
24 this section of it, and my Category 1 are focused

1 on prevention, the answer is yes.

2 Q. Oh, let me -- let me be real simple about
3 it, Doctor Alexander. You say the first thing you
4 need to do is focus on prevention, right? That's
5 your Category 1. That is the header, correct?

6 MR. BURNETT: Objection,
7 mischaracterizes.

8 A. Yeah, it's the first category. I'm not
9 saying that it's the first thing. I mean, we need
10 to do a bunch of stuff simultaneously. It's not --
11 this isn't a linear process.

12 Q. I understand --

13 A. But it is Category 1.

14 Q. I understand. It is Category 1 of your
15 plan, correct?

16 A. Yes, ma'am.

17 Q. Okay. And has Cabell County/Huntington
18 also engaged in a number of programs under their
19 title "Prevention and Early Intervention?"

20 A. I believe they have.

21 Q. Okay. And if we look through The City of
22 Solutions guide, over the next through pages, does
23 it outline a number of these programs?

24 A. Yes, it does.

1 Q. Okay. And some of these programs that have
2 -- have already been in place and are in place in
3 the community are Project Engage, correct?

4 A. Yes.

5 Q. And you're familiar with Project Engage?

6 A. Yes, ma'am.

7 Q. And what does Project Engage seek to do?

8 A. It seeks to better link individuals in
9 clinical settings with treatment for substance use
10 disorders.

11 Q. So when you say "clinical settings," are we
12 talking about individuals who end up in the
13 emergency department, for example, and there's
14 somebody there - a peer recovery coach - to provide
15 them with information and access to treatment
16 should they choose to engage in treatment? True?

17 A. Yes. Yes, for example.

18 Q. Okay. And this is something that Cabell
19 County/Huntington has had in place and does have in
20 place now, correct?

21 A. Yes. But I -- I mean, programs aren't --
22 yeah, I mean, it may not be adequately resourced;
23 it may not be optimally funded. It may not be
24 optimally staffed.

1 So just because there is a program in
2 place, I'm not disparaging the program, and in
3 fact, I think, you know, it plays a very important
4 role. But I wouldn't want to misconstrue the
5 presence of a program or equate that with its
6 adequate deployment, support, funding and long-term
7 viability.

8 Q. And is Project Engage part of a
9 collaboration effort with any of the health care
10 facilities in the area?

11 A. Well, I think it would have to be. I don't
12 know details about that, although I do see and --
13 that Christiana Healthcare as a reference, although
14 that's in Delaware -- and Marshall University and
15 the health system that I believe is related to that
16 corporately or structurally, may well be an
17 important part of that.

18 But I don't know the details of the
19 health care systems that may have formally signed
20 on.

21 Q. Are you -- are you not aware that St. Marys
22 Medical Center and Cabell-Huntington Hospital have
23 worked together to pioneer the Project Engage
24 effort since 2017?

1 A. I am --

2 MR. BURNETT: Objection.

3 A. I'm sorry. I am aware of St. Mary's; I'm
4 not -- you know, I don't know the formal sort of
5 corporate relationship or flow of money or
6 resources between this project and St. Mary's or
7 the corporation that it represents.

8 Q. And you're not aware or offering any
9 opinion that the City or the County needs to spend
10 any funds, spend any money, relating to Project
11 Engage. Is that correct?

12 A. I wasn't asked to identify who pays the
13 bills. I was -- I was simply asked to identify
14 what I thought would be an evidence-based abatement
15 program for this community.

16 Q. And in terms of what you just said, Doctor
17 Alexander, so just to confirm, you don't have any
18 opinion in this case that the City of Huntington or
19 Cabell County generally has been responsible for
20 funding any of the programs that they have had in
21 place to date. Is that correct?

22 A. And here you --

23 MR. BURNETT: Objection.

24 A. Here you mean beliefs or legal opinions?

1 Q. You're not offering opinions in the case,
2 as an expert, that Cabell County or the City of
3 Huntington has had to fund any of the programs that
4 they have decided to put in place to address the
5 opioid epidemic.

6 MR. BURNETT: Objection.

7 A. No. No, I'm not.

8 Q. Okay. And in terms of future payments,
9 you're not offering any opinions that should your
10 plan for abatement be put in place in Cabell
11 County/Huntington that any aspect of the plan would
12 need to be paid for or funded by the City or
13 County. You're not offering opinions as to that;
14 is that correct?

15 A. Yeah, that's for the judge to decide,
16 you're correct.

17 Q. Okay.

18 A. Or somebody -- it's not for me to decide,
19 let me put it that way.

20 Q. Not for you to decide who pays, correct?

21 A. Correct.

22 Q. You have a plan in place, hopefully a very
23 comprehensive plan - hopefully we'll get through
24 that - but you don't have any opinions as to the

1 allocation of funds: Who will pay, who should pay,
2 how it's divvied up; is that fair?

3 A. Yes, that's fair.

4 Q. Okay. Now, back to what the community has
5 done in terms of prevention and early intervention,
6 I assume you are very familiar with the Quick
7 Response Team?

8 A. Yes, I am.

9 Q. And if you look at The City of Solutions
10 guidebook, you can read about the Quick Response
11 Team on page 18 and the pages following after. And
12 who makes up the Quick Response Team, Doctor
13 Alexander?

14 A. Well, generally this is a team -- I mean,
15 it varies place to place and community to
16 community, but in general, this includes some sort
17 of health care professional or addiction expert,
18 often a -- at times, it can include a faith-based
19 leader or someone from a faith community.

20 It can have a peer recovery coach, can
21 sometimes participate in these teams. The teams
22 may or may not include a law enforcement officer.
23 At times, there's concern that that may, you know,
24 scare people off, for lack of a better word.

1 But those are the types of people that
2 participate in these teams.

3 Q. Okay. Well, let's just talk about Cabell
4 County/Huntington. Who makes up the Quick Response
5 Team in Cabell County/Huntington?

6 A. I think that's depicted here in this
7 exhibit, which indicates "a paramedic" or "EMT,"
8 "law enforcement officer," "peer recovery coach" or
9 "clinician" and a "spiritual or faith leader."

10 Q. And what types of services does the Quick
11 Response Team provide?

12 A. Well, this is a good example where I
13 believe that this is covered in my Ohio report --
14 not to open, you know -- not to go back too far
15 there. But this is a good example where I believe
16 even though linkages as to care may not have been
17 called out as a separate category in my Ohio
18 report, nevertheless, the QRT or Quick Response
19 Team is exactly -- does exactly this.

20 I mean, they can provide a very
21 important role in linking people to care that
22 otherwise would fall through the cracks.

23 I mean, you have a narrow -- you have
24 a narrow window of opportunity when someone

1 overdoses, and it's a -- it's an opportunity, in
2 many cases, to help people get into treatment.

3 And part of the benefit of a Quick
4 Response Team is that well-designed and well-
5 deployed, they can serve an important role in
6 helping to bridge people to care.

7 Q. And this Quick Response Team in Cabell
8 County/Huntington, it has a project director and a
9 coordinator?

10 A. I -- it -- I mean, it appears at the time
11 that this report was written that it did. I can't
12 speak to whether or not it's currently staffed at
13 those levels or not.

14 Q. And you note that the team works "a
15 40-hour-per-week schedule." Do you see that?

16 A. Well, this isn't my -- what we're looking
17 at here is if -- I mean, you said "you note."

18 Q. It's in the document. I mean, you've read
19 this document --

20 A. I've reviewed it and I'm familiar with The
21 City of Solutions, yes. But I'm sorry, I was
22 confused when you said "you note." But they may
23 well work a 40-hour week. That may well be the
24 case.

1 Q. And do you know how they came about getting
2 the vehicle that the Quick Response Team uses?

3 A. I think that's an interesting question. I
4 think it may have been donated but I don't recall
5 the details of where they came by the vehicle.

6 Q. It's in the document. I actually says it
7 was donated. You are correct.

8 A. Okay.

9 Q. Now, in terms of other Harm Reduction, that
10 starts on page 20 of The City of Solutions
11 guidebook, correct?

12 A. Yes, ma'am.

13 Q. Okay. And you said to me earlier, I think,
14 that that was a very important initiative that the
15 community had taken to get ahead of Harm Reduction;
16 is that right?

17 A. I mean, they're all -- they're all
18 important. I'm sorry, but I -- I -- I mean,
19 they're all important interventions. But I do just
20 want to call out and remind you, this was a
21 document that was written at one point in time and
22 so -- but yes, Harm Reduction is important and it's
23 my understanding that the County and the City have
24 done -- have provided some leadership in developing

1 a syringe service program.

2 And I do think it's an important
3 component, yes.

4 Q. And if you look with me at the -- at the
5 document, other than the syringe services program,
6 what other types of programs and interventions has
7 the community been able to implement to further the
8 goal of Harm Reduction?

9 A. Well, some people consider naloxone a means
10 of harm reduction. I suppose it's -- it depends
11 who you ask whether you characterize that as harm
12 reduction, but as has been stated by community
13 leaders and in the community itself, you know,
14 naloxone alone isn't gonna get you out of this
15 mess, and you can't just resuscitate someone from
16 an overdose and then expect them to, you know,
17 magically appear in treatment.

18 So naloxone is one. Fentanyl testing
19 is another approach that is sometimes used to see
20 whether there's evidence of fentanyl in -- in what
21 may be counterfeit prescription opioids that are
22 circulated, or in heroin.

23 And then, you know, I just want to
24 note that harm reduction services don't -- it's not

1 just about giving people syringes, it's about --
2 again, we're back to linkages to care. You know, I
3 have -- there's a saying that "The road to recovery
4 is paved with relationships," and so Harm Reduction
5 outreach allows for one to develop relationships
6 and also provide primary care to these people, not
7 just give them syringes.

8 Screen them for HIV, hepatitis and the
9 like. So I hope that helps give you a sense.

10 Q. And are you familiar with the Great Rivers
11 Regional System for Addiction Care? If we look at
12 page 26? Are you familiar with that program?

13 A. Only -- not -- not -- you know, I reviewed
14 this and I reviewed that program, but I'm not as
15 familiar with that as some of the other programs
16 we've considered.

17 Q. Did you do any independent research? Did
18 you go on the website and read about Great Rivers
19 Regional System for Addiction Care, read about what
20 they do, read about who they treat?

21 A. Well, I certainly read about PROACT, and I
22 see here PROACT is called out as a means -- as a
23 means to -- you know, as one component of this
24 system of addiction care.

1 And again, I reviewed an enormous
2 number of materials and spoke with a large number
3 of people on the ground about the state of
4 addiction care in the county and the city.

5 Q. Well, my question was: Did you do any
6 reading or research about the expansive programs
7 offered through Great Rivers Regional System for
8 Addiction Care?

9 A. I did do some -- I did review publicly-
10 available information. I don't recall having
11 reviewed in depth this particular system.

12 Q. Can you tell me who runs the program, which
13 health facility, health care facility, runs Great
14 Rivers Regional System for Addiction Care?

15 MR. BURNETT: Objection.

16 A. I mean, we've talked about -- I would want
17 to review this -- this document further. But we've
18 talked about some of the -- you know, the important
19 health systems within the community. I know that
20 St. Mary's and Marshall University have played
21 important roles, but I --

22 If you're asking about what the source
23 of funding is for this regional system, my guess is
24 it subsists on a variety of funding and that some

1 of it may come from a state or county budgets.

2 Q. You're not aware that the Great Rivers
3 Regional System for Addiction Care is through
4 Marshall Health?

5 MR. BURNETT: Objection.

6 A. I'm familiar with -- I'm familiar with the
7 important role that Marshall Health plays in Cabell
8 County and the City of Huntington in addressing
9 many dimensions of the opioid epidemic, and I'm
10 familiar with the investments that Marshall has
11 made in helping to expand the availability of
12 treatment for people with opioid use disorder.

13 So yes, I'm familiar with the
14 important role that the University and the health
15 system has played.

16 Q. Did you do any research to inform yourself
17 as to the significant number of West Virginia
18 residents struggling with mental health disorders
19 and poor quality of life generally?

20 A. Yes, that was part of the materials that --
21 I mean, that -- the issue of mental health and many
22 other -- many other sort of contacts that help
23 create the fabric of this Appalachian community are
24 ones that I reviewed and explored in understanding

1 how we got to where we're at in Cabell County and
2 the City of Huntington.

3 Q. Well, do you agree with what is written
4 here, from your research, that many West Virginia
5 residents contend with complicating risk factors --
6 and this is risk factors for addiction; is that
7 right?

8 MR. BURNETT: Objection. Are you
9 reading from a document?

10 MS. GEIST: I'm reading right from the
11 screen.

12 A. Can you point out --

13 Q. Can you agree with what is written here by
14 the community itself, that "Many WV residents
15 contend with complicating risk factors" "such as
16 trauma, intimate partner violence, and other
17 chronic diseases." And that "These issues are
18 influenced by poor access to health care, low
19 health literacy levels, low levels of educational
20 attainment, and high numbers of unemployment?"

21 Do you -- are you aware of all that,
22 Doctor Alexander, from your own research and
23 review, of the challenges faced by this community?

24 A. Yes, I am. And if I could just ask if you

1 could please enlarge the screen size a little bit?

2 Q. I wish I could, but I can't.

3 MS. GEIST: But perhaps my friend John
4 can do that so we can pop out the bottom paragraph.

5 A. Yeah, that's fine. Just going forward, my
6 vision isn't quite what I wish it were. I do agree
7 with the -- with the question, which was about the
8 -- you know, the fact that many West Virginia
9 residents have, you know, other potential risk
10 factors or - as this puts it - "complicating risk
11 factors," right.

12 So in some cases, these may predispose
13 to developing addiction; and in other cases, they
14 certainly don't make recovery from addiction
15 easier.

16 Q. Would you agree with me -- and this is all
17 true of the residents of Cabell County/Huntington,
18 correct?

19 A. Yes, in broad -- in broad form. I mean,
20 the rates of specific things like posttraumatic
21 stress or intimate partner violence may vary county
22 to county but yes, I think this is true at both a
23 state and county level.

24 Q. Would you agree with me that both the

1 problems and challenges in this area of the country
2 - rural Appalachia - go way beyond opioid use
3 disorder or even substance use disorder?

4 A. Without a doubt.

5 Q. And if we look at The City of Solutions
6 document that we've been working through together
7 now, if you go all the way to page 93 of that
8 document -- have you read before this section,
9 Doctor Alexander? It's --

10 A. As with any of the hundreds of documents
11 that I've reviewed and relied upon for my report, I
12 can't ascertain that I've read every word of every
13 document, but I'm certainly familiar with this --
14 this important document, and I did review it
15 carefully in the course of developing my report.

16 Q. Okay. And then -- so you read here the
17 community's own description that while there's
18 strategies described in their own plan -- "will
19 help reduce both the supply of and demand for drugs
20 in the Huntington area, they may not be sufficient
21 for addressing the opioid crisis in the long run.

22 The area's epidemic emerged with the
23 statewide decline in the manufacturing, coal mining
24 and construction industries."

1 Are you aware of all of that?

2 MR. BURNETT: Objection.

3 A. I am -- I am aware. I mean, there are very
4 important contextual factors that have helped fuel
5 the epidemic in Cabell County and the City of
6 Huntington, but to make an epidemic, it doesn't
7 just take biology and environment; it also takes
8 supply and access.

9 And so I think these factors are very
10 important, and my abatement plan is designed to
11 help address them. I consider things like mental
12 illness and vocational training and homelessness --
13 in fact, many of the categories that you are asking
14 about and sort of querying and contrasting between
15 my Ohio report and my West Virginia report, are
16 specifically categories intended to address these
17 very problems.

18 So I'm aware of these problems, and I
19 think that they're important, and my abatement plan
20 has to be informed by them, and it is.

21 Q. Now, do you agree with me then that if your
22 abatement plan were to be implemented - either in
23 whole or in part - by the Court in this case, it
24 would not cure or eliminate opioid use disorder or

1 substance use disorder generally in Cabell County/
2 Huntington?

3 A. Well, I propose that it will decrease -- I
4 believe I make scientific estimates based on my
5 professional experience that I think we can
6 decrease the number of people with opioid use
7 disorder and with overdose by 50 percent over 15
8 years.

9 Q. Understood. But my question was a little
10 different, so let me try it again. Do you agree
11 with me that even -- let's assume your plan is
12 implemented in full, every aspect of your plan is
13 implemented by the Court, do you agree with me that
14 that is not going to cure or eliminate opioid use
15 disorder or substance use disorder in Cabell
16 County/Huntington?

17 A. Yes, I agree that it won't 100 percent
18 eliminate all opioid use disorder, yes.

19 Q. And you agree with me that there is always
20 going to be some level of opioid use disorder or
21 substance use disorder in West Virginia and in
22 Cabell County -- at -- in part, at least, due to
23 the issues reflected here in this document relating
24 to mental health, manual employment jobs and

1 basically poverty and the loss of industry.

2 All of that will impact the future of
3 this region of the country. True?

4 MR. BURNETT: Objection. Outside the
5 scope.

6 A. Well, it felt to me a little bit like two
7 different questions, but what I can say is that I
8 think that poverty, unemployment, the loss of
9 manufacturing, the loss of economic opportunity,
10 posttraumatic stress, intimate partner violence,
11 you know, these are all important contextual
12 factors, and my abatement plan was not designed -
13 nor was I asked to design an abatement plan - to
14 eliminate all of these entirely.

15 Q. Right. And you agree that no abatement
16 plan could eliminate all of these structural issues
17 in this -- in this area of the country. Agree?

18 A. Or -- or anywhere. I mean, you're not
19 gonna eliminate them. The idea is -- the idea is
20 not to eliminate them; the idea is to mitigate the
21 impact of these on -- on -- on the population as it
22 manifests through addiction and through overdose.

23 And again, that's why there are so
24 many strategies that are needed, and they need to

1 be deployed simultaneously and with a lot of
2 resources behind them.

3 Q. And due to either the mental health issues
4 in the region or the poverty or their loss of jobs,
5 some individuals in Cabell County/Huntington will
6 always turn to drug use for a variety of reasons.
7 Is that correct?

8 A. Well, these -- I mean, these are -- there
9 are complex determinants of addiction, as I think
10 other experts have opined, and as I would submit.
11 And so -- people don't develop addiction because of
12 X. There are complex determinants.

13 But I think most broadly, I find it
14 helpful to think about the biologic or genetic
15 determinants, the social, economic, psychological
16 determinants and then the issue of supply and
17 access.

18 And so that's -- that's, I guess, the
19 framework that I use.

20 Q. And because of all of these complex
21 determinants that we've been discussing, do you
22 agree with me that there are individuals who,
23 today, do not have opioid use disorder or even
24 substance use disorder, but will develop opioid use

1 disorder or substance use disorder at some time in
2 the future?

3 A. Yes, I hope far fewer than -- I hope with
4 an abatement plan, and I think with an abatement
5 plan, far fewer than would otherwise.

6 But yes, I think there will be some
7 individuals that develop opioid use disorder or
8 other substance use disorders down the road
9 regardless.

10 Q. Okay. And certainly this will occur within
11 the next 15 years, which is the time frame that
12 you're proposing for the implementation of your
13 abatement plan. Correct?

14 In other words, there will be
15 individuals who, today, do not have opioid use
16 disorder, do not have substance use disorder, but
17 they will develop either one or the other within
18 the next 15 years, which is the time frame for your
19 abatement plan. True?

20 A. Yeah, I mean, there are -- there are many
21 people that are taking opioids chronically right
22 now in Cabell County and the City of Huntington. I
23 mean, there are still an enormous volume of opioids
24 that are prescribed by licensed prescribers, and

1 some of these individuals may develop addiction in
2 a month or a year.

3 So absolutely, I think that there are
4 some individuals that don't have addiction today
5 that may develop addiction down the road, even if
6 the abatement plan is deployed.

7 Q. And do you also agree with me that some of
8 the individuals in Cabell County/Huntington who are
9 being prescribed opioids under the care and
10 treatment of a physician and are using them as
11 prescribed will not develop opioid use disorder.
12 True?

13 A. Yes, I believe that's the case also. Not
14 everybody develops addiction. Although I would say
15 that there's still many, many people that are on
16 prescription opioids chronically that shouldn't be
17 on them.

18 So it's not just like, "Well, if you
19 don't develop addiction, then there's no sweat with
20 being on them." They're actually not only pretty
21 unsafe - or very unsafe in many settings - they're
22 not that effective for the treatment of chronic
23 pain.

24 So -- but yes, I agree with your --

1 your point.

2 Q. Do you also agree with me that there's
3 individuals today who are not using prescription
4 opioids but who may develop opioid use disorder or
5 substance use disorder generally within the next 15
6 years in Cabell County/Huntington?

7 A. I do, yes.

8 Q. Okay. So there is -- we know and expect --
9 just from the nature of addiction and the
10 conditions in Cabell County/Huntington -- that
11 within the next 15 years, there will be new addicts
12 who are not yet using any type of opioid today.
13 True?

14 A. Well, I mean, I -- I try to avoid the term
15 "addicts" because I think it's a bit stigmatizing,
16 but the bottom line is I think there will be new
17 people who develop addiction, yes.

18 Q. Okay. Including opioid use disorder who
19 are not using currently, correct?

20 A. Yes. Yes.

21 Q. And those individuals -- looking forward,
22 these individuals, in the next 15 years, would be
23 beneficiaries if your abatement plan is put in
24 place in whole or in part, correct?

1 A. Well, I mean, I think we discussed this a
2 little bit in different contexts. But I guess I'd
3 like to make two points. One is that we talked a
4 little bit already about how the prescription
5 opioid market affects heroin markets, so I'm not --
6 while I wasn't asked to focus on this in my report,
7 I think it's worth noting that -- that -- that
8 heroin markets are impacted by demand for opioids,
9 even among individuals that may have an opioid use
10 disorder that originated from prescription drugs.

11 But -- but with respect to whether
12 they'll be beneficiaries that, you know, of my plan
13 that didn't develop opioid addiction because of
14 prescription opioids, I think that too we discussed
15 previously, and I think my -- my response is that
16 my plan is -- was not focused -- I didn't try to
17 disaggregate my plan based on whether or not
18 someone was currently using prescription opioids or
19 heroin or fentanyl.

20 It's just not the way - from a public
21 health perspective - that one tackles this type of
22 problem in a community. We would never turn
23 someone away from an emergency department and say,
24 "Well, you know, you're a heroin user. If it was

1 prescription opioids, I've got a phone number for
2 you, but since it's heroin, we're not gonna offer
3 it."

4 And frankly, many people that use
5 heroin and fentanyl illicitly, they started with
6 prescription opioids, the majority. So -- so I
7 didn't disaggregate those components in my plan.

8 Q. Okay. I just wanted to make sure I
9 understood your answer, because it was a little
10 long.

11 A. All right.

12 Q. My question was: Going forward, if
13 individuals today in Cabell County/Huntington, they
14 do not have opioid use disorder, they do not have
15 substance use disorder, they are not using
16 prescription opioids, you agree with me that those
17 individuals -- there are individuals with those
18 facts who may at some point in the future develop
19 opioid use disorder who would be beneficiaries of
20 your 15-year plan should it be put in place.

21 A. Yes, there are, and I believe they should
22 be included in my plan for reasons that I've
23 articulated.

24 Q. Okay. And this would also -- just to be

1 clear, Doctor Alexander. I think you answered
2 this, but I want to make sure I understand it.
3 This would include individuals who never touched a
4 prescription opioid, and in the future, they may
5 start using heroin or fentanyl or carfentanil and
6 develop opioid use disorders.

7 Those individuals would also be
8 beneficiaries of your 15-year abatement plan should
9 that be put in place, correct?

10 A. Yes, they would be beneficiaries, and I
11 believe they should be included in my plan for
12 reasons that I've already explained.

13 Q. By the way, I forgot to ask you this -- we
14 will get to it later, but in terms of the component
15 parts -- but we've been talking about your plan a
16 lot. Are you aware and familiar with the estimate,
17 the cost estimate, to implement all of the
18 interventions and programs that you're proposing in
19 your plan over a 15-year time period?

20 A. Yes, at a high level, I am.

21 Q. Okay. How much?

22 A. I believe it was between 2.6 and 2.7
23 billion, with a B.

24 Q. And that's just for Cabell County/

1 Huntington, correct?

2 A. Yes, I believe so.

3 Q. Now, going back briefly to The City of
4 Solutions document that we were discussing
5 together, that document - if you flip a little bit
6 forward to page 31 with me - that talks about a
7 program that the community has had in place called
8 WEAR, W-E-A-R, all caps, and it's within a section
9 talking about the Drug Court in general.

10 And do you know what WEAR stands for,
11 Doctor Alexander?

12 A. I don't, but I'm quite familiar with the
13 Drug Court itself. But I don't know what the
14 acronym stands for.

15 Q. Okay. Well, there's Drug Court, and then
16 there's a separate program for women titled WEAR,
17 W-E-A-R. Are you familiar with that program?

18 A. Yes, I am.

19 Q. And is -- is there also a separate juvenile
20 Drug Court?

21 A. I believe so, but I'm not positive. I can
22 certainly say that having reviewed drug courts and
23 their performance, I -- I think it's an important
24 part of -- of abatement for this community.

1 Q. And I assume, based on your prior answer,
2 you did not investigate or research who provides
3 the funding for the Drug Court, the juvenile Drug
4 Court, and WEAR; is that correct?

5 A. Yeah, I was not asked to examine the
6 sources of funding for currently-existing programs.

7 Q. Okay. Why don't you go with me, please, to
8 page 33 of The City of Solutions document. And
9 there it talks about CCSAPP. What does that stand
10 for, if you know?

11 A. Well, it's provided here on the document
12 itself. But it's the Cabell County Substance Abuse
13 Prevention Partnership.

14 Q. Okay. And would you agree with me that's
15 an example of an excellent comprehensive
16 collaborative approach to the problem in Cabell
17 County?

18 MR. BURNETT: Objection.

19 A. I mean, those are your words. I wouldn't
20 -- I wouldn't want to characterize. Again, I
21 wasn't asked to perform a comprehensive review or
22 evaluation or sort of give a grade to any specific
23 program.

24 Q. Well, you talk a lot about the importance

1 of community coalitions in your own plan, don't
2 you?

3 A. I do. I think they are important. You
4 know, the fabric of this community has been
5 shredded in some ways, so I think that these types
6 of coalitions do play an important role in
7 communities such as this.

8 Q. Okay. And this is an example of one of
9 those coalitions that you suggest in your plan,
10 true?

11 A. Yes, it is.

12 Q. Okay. And what does -- what does the
13 Cabell County Substance Abuse Prevention
14 Partnership do?

15 A. I would want to look at this in more
16 detail. If that's helpful, I'm happy to do so with
17 you.

18 Q. I just wanted to know if you could tell me
19 sitting here as we talk about CCSAPP?

20 A. Well, generally these type of community
21 coalitions are important because they help to
22 support primary prevention within communities, and
23 so if we look, for example, at my report and the
24 reasons that I argue that community coalitions are

1 important, it's because they represent an important
2 stakeholder and they can provide opportunities for
3 youth that may otherwise be hanging out and be more
4 likely to use products nonmedically or to get into
5 trouble.

6 They provide, oftentimes, community
7 meeting spaces. They can serve as a venue for the
8 conduct of media campaigns and social marketing
9 campaigns. They provide linkages, essentially,
10 between different organizations and so --

11 Q. And so -- I'm sorry. Were you finished.

12 A. Well -- and so -- I was just going to say
13 in closing that they help to -- they help to weave
14 a fabric that can help build resiliency within
15 different communities.

16 Q. Now, I actually didn't want to talk about
17 these programs or coalitions in general; I wanted
18 to ask you what you could tell me about this
19 particular Cabell County coalition and what they
20 did or what they provide.

21 A. Yeah, well, I think that they provide --
22 again, it's been a while since I've looked at this
23 document and considered this particular coalition,
24 but my guess is that they provide some of the types

1 of services and opportunities that I've just
2 discussed.

3 Q. And are you aware that they are funded
4 through Federal funding, SAMHSA and otherwise?

5 A. Again, I was not asked to examine the
6 funding of different organizations.

7 Q. And other than providing those top-level
8 generalities, can you give me any specifics about
9 what the Cabell County Substance Abuse Prevention
10 Partnership does for the community?

11 MR. BURNETT: Objection. Outside the
12 scope.

13 A. Yeah, I think I've hopefully given you a
14 sense of the role that I think these organizations
15 play and the -- the importance that they can serve
16 in helping to promote primary prevention and reduce
17 the likelihood that people develop substance use
18 disorders.

19 Q. Doctor Alexander, what can you tell me
20 about the LEAD program?

21 A. Very --

22 Q. In Cabell County. Not in -- and again, I
23 would like you to be specific about the LEAD
24 program in Cabell County/Huntington if you can do

1 that.

2 A. Sure. And are you referring to a
3 particular place in this report? Or no?

4 Q. I'm just asking you generally if you can
5 tell me what you know about what the LEAD program
6 provides for the community in Cabell County.

7 A. Sure, sure. So LEAD stands for Law
8 Enforcement Assisted Diversion, and this is a -- an
9 important means of diverting nonviolent offenders
10 from the criminal justice system.

11 So individuals that have opioid use
12 disorder or other substance use disorders that may
13 engage in nonviolent crimes, property theft, for
14 example, the LEAD program provides an opportunity
15 for these individuals to enter treatment rather
16 than go to jail.

17 And it's a brilliant -- I mean, it's
18 an important program that is, unfortunately,
19 underutilized in some parts of the country, and it
20 gives people a second chance. And it recognizes
21 that no one chooses to have addiction any more so
22 than they choose to have colon cancer or multiple
23 sclerosis.

24 So it gives people that second chance

1 by allowing them to be processed through the
2 treatment system rather than the criminal justice
3 system.

4 Q. How successful has the LEAD program been in
5 Cabell County?

6 MR. BURNETT: Objection.

7 A. Again, I wasn't asked to provide -- you
8 know, I wasn't asked to provide a -- I wasn't asked
9 to provide an estimate or an evaluation of -- of
10 any specific program regarding their -- their
11 success, but I did review, you know, dozens or
12 hundreds of documents, and some of them included
13 information on the performance of these different
14 programs.

15 Q. But sitting here today, you are unable to
16 tell me any specifics about the success of the LEAD
17 program in Cabell County?

18 MR. BURNETT: Objection.

19 A. What -- what would you -- are you looking
20 for a certain number? Or what would you -- what
21 measure are you asking about and looking for when
22 you ask how successful do I think the program is?

23 Q. I'm just -- I'm asking you if you can
24 provide to me any -- any specifics about the LEAD

1 program in Cabell County. Obviously there's LEAD
2 programs throughout the United States, correct?

3 A. Yes, there are.

4 Q. And they all generally have the same goals
5 and they generally do the same things, and so while
6 I appreciate the answer you provided me, I wanted
7 to know if you could tell me anything specifically
8 about the achievements of the LEAD program in -- in
9 Cabell County.

10 MR. BURNETT: Objection.

11 A. I think it's been an important program, and
12 my sense is that it's served a very important role
13 in Cabell County in helping to allow for people to
14 avoid getting channeled into the criminal justice
15 system, which is not where people with addiction
16 should be.

17 So I don't have a top-of-mind number
18 or -- I don't have a top-of-mind number for the
19 number of people, for example, that were processed
20 in 2018 through the LEAD program but for the
21 presence of the program would otherwise have ended
22 up in jail.

23 You know, I reviewed -- I've already
24 noted the number of -- of data sources and

1 information points and data points that I've
2 reviewed in the course of preparing my report. And
3 I'd be happy to look at information with you that
4 I'm sure that I cite in my report or in my redress
5 models that does provide some of that context that
6 you may be looking for.

7 Q. Now --

8 A. May I -- I'm sorry to interrupt, but I'd be
9 happy within the next ten or fifteen minutes for a
10 break.

11 MR. BURNETT: Yeah, same.

12 Q. I was going to move on to treatment
13 briefly. So it's a great time to take a break.
14 Why don't we come back at 4:00.

15 And Justin, would you mind -- can I
16 have the time on the record, please?

17 VIDEO OPERATOR: Yeah, give me one
18 moment. The time is 3:48. We are going off the
19 record.

20 (A recess was taken after which the
21 proceedings continued as follows:)

22 VIDEO OPERATOR: The time is
23 4:00 o'clock. We are now back on the record.

24 BY MS. GEIST:

1 Q. Doctor Alexander, let's turn now to
2 treatment, if we could, please, and the discussion
3 of the treatment programs available in Cabell
4 County/Huntington begin on page 38 of The City of
5 Solutions guidebook, if you want to go there.

6 A. Okay.

7 Q. Are you there with me?

8 A. Yeah.

9 Q. Okay. The first program that's discussed
10 is Project Hope for Women and Children. Do you see
11 that?

12 A. Yes, I do.

13 Q. Okay. What does Project Hope for Women and
14 Children do? Or provide, rather.

15 A. I believe it provides housing and other
16 services for -- for women that have been impacted
17 by the opioid epidemic and their children. So it
18 -- it gives people a chance to get back up on their
19 feet and has services that are discussed here in
20 the materials that you're showing as well as the
21 subsequent pages regarding counseling and therapy
22 groups and peer coaches and program assistance and
23 the like.

24 Q. Does it also address women who have

1 co-occurring mental health or mental health
2 disorders?

3 A. Yes, I believe that it does.

4 Q. And does it also provide housing for women
5 and children?

6 A. It does. As with all of these programs
7 we're considering, you know, the level of support,
8 the sources of support, the ability to scale this
9 to meet continued unmet need is -- is important to
10 consider.

11 So I think those are important, you
12 know, dimensions of this. But yes, it does provide
13 those services.

14 Q. And then who's the main partner with Cabell
15 County/Huntington in connection with Project Hope?

16 A. Well, I think Marshall University or
17 Marshall Health has -- has played a very important
18 role. I believe that this program previously was
19 City Mission and that the -- the residences or the
20 facilities and the infrastructure and support was
21 subsequently taken over by Marshall -- Marshall
22 Health, I believe.

23 Q. In your research and review of materials
24 for this case, any indication that there was any

1 sort of capacity issue with respect to the
2 apartment housing provided by Project Hope?

3 A. Well, I carefully considered existing
4 programs and services within the community as I
5 developed my recommendations, but I did not do -- I
6 was not asked to perform a needs assessment per se,
7 so I not attempt in my abatement plan to net out
8 current levels of care and only propose the margin,
9 essentially only propose what I thought -- what
10 additional should be provided.

11 Q. Well, let me ask you this: Generally would
12 you agree with me that virtually every aspect of
13 your proposed abatement plan, the programs and
14 interventions you have in the plan, there is some
15 aspect of that already in place in Cabell County/
16 Huntington? That's true, isn't it?

17 A. Yes. To varying -- to markedly varying
18 degrees. But yes, I believe that's the case.

19 Q. And for the most part, from my review of
20 your plan, you acknowledge that these
21 implementations or interventions or programs have
22 been put in place, but more times than not, your
23 proposal was to add on or expand. Is that a fair
24 characterization?

1 A. Again, my program builds on what's been
2 deployed in the community, but I didn't try to
3 identify some level of provision of services which
4 my program would add to.

5 Q. So sitting here today, you can't tell me
6 whether or not there's been issues with a waiting
7 list at Project Hope, for example or whether that
8 the housing services provided by Project Hope have
9 been insufficient to address the needs of the
10 women and children for whom those programs are
11 intended.

12 Is that correct?

13 A. No, I believe that's incorrect.

14 Q. Well, then I'll go back to my question I
15 had asked you: Is there any issue with the
16 apartment housing provided to women through a
17 partnership with Marshall Health and Project Hope
18 -- is there any issue with capacity or not having
19 enough apartments, essentially?

20 A. Yeah. So thank you for that question. You
21 know, the vast majority of people with opioid use
22 disorder are not in treatment currently. And that
23 -- that's the case in Cabell County and the City of
24 Huntington just as it is elsewhere in the country.

1 And so I would never want to look at a
2 certain level of services or sort of whether or not
3 Lily's Place or Project Hope or, you know, some
4 other organization -- I would never want to look at
5 the current level of -- of services provided and
6 say, "Well, because Project Hope on average has two
7 beds open on a given night, we don't need to invest
8 further in providing housing for women and children
9 that may be impacted by the opioid epidemic in the
10 community."

11 So my point is that there's large,
12 large amounts of unmet need and that we have
13 identified and successfully reached out to only a
14 minority of those individuals.

15 So I think that many of these programs
16 can be substantially scaled, and in fact, my plan
17 proposes to do so over 15 years.

18 Q. But in other words, Doctor Alexander, you
19 agree with me that with respect to a program like
20 Project Hope, for example - and you also mentioned
21 Lily's Place - you can't tell me today that,
22 through your research and review, you determined
23 that they didn't have enough beds, they didn't have
24 enough apartments, they didn't have enough places,

1 they couldn't handle the capacity.

2 You can't tell me any of that. Is
3 that true?

4 MR. BURNETT: Objection, asked and
5 answered.

6 A. I considered the current volume of care in
7 these programs as I -- as I reviewed them. But my
8 point is that there's large amounts of unmet need
9 within the community, and so even though they may
10 or may not be at capacity now, I don't think that
11 that -- that there's a large amount of unmet need.

12 And again, I wasn't asked to do a
13 needs assessment of specifically how many beds are
14 currently occupied or how many people are currently
15 in treatment that are being paid for by the City or
16 State or County and how many additional people
17 should be treated.

18 My abatement plan just looks at the
19 total populations that I believe are going to need
20 services.

21 Q. I see. So for -- for all of the different
22 programs here under the heading of Treatment in The
23 City of Solutions guide, we have -- we have Project
24 Hope; we have Lily's Place; we have Recovery

1 Support; Healthy Connections, a variety of
2 different programs.

3 You don't have any information, based
4 on your review, that any of these programs are at
5 capacity now or have had a waiting list.

6 Is that correct?

7 MR. BURNETT: Objection.

8 A. I didn't try to quantify -- if you're
9 asking whether I tried to quantify sort of current
10 levels of staffing or provision of care and
11 incorporate these quantitatively into my abatement
12 program, the answer is no, that I did not do so.

13 Q. Okay. So the answer to my question is:
14 You can't tell me that any of these programs are at
15 capacity. True?

16 MR. BURNETT: Objection.

17 A. Well, I mean, if you take something like
18 the LEAD program or like Quick Response Teams or
19 the Drug Courts, they may be at capacity, but there
20 may be a -- huge opportunities to expand them
21 further.

22 So again, I think the issue of
23 capacity is relative and the question is capacity
24 at what point in time and with what level of

1 outreach and what level of initiative and
2 investment to identify those that could benefit
3 from the program.

4 And so I'm -- but I did not look and
5 try to quantify or evaluate the specific current
6 levels of staffing or provision of care in any
7 given program. That's correct.

8 Q. Okay. So you went back to prevention a
9 little bit, so I do want to ask it again. I'm
10 talking about treatment now. We're under the
11 heading of "Treatment," talking about Project Hope,
12 Lily's Place and similar treatment programs
13 available in Cabell County.

14 Just so I'm clear, in forming your
15 abatement plan, you did not look to determine
16 whether or not any of these treatment programs were
17 at capacity, whether there was a wait list or
18 people waiting to get in. You did not do that in
19 forming your opinions in the case. Is that correct?

20 MR.BURNETT: Objection, asked and
21 answered several times.

22 A. It is correct, but I would like to just
23 call out that this is part of a broader discussion
24 in a number of other points that I've already made.

1 Q. Okay. Doctor Alexander, can we go back to
2 your expert report in the case, please, which is
3 Exhibit 4?

4 A. Okay.

5 Q. I will like to run through some of the
6 proposals that you have in your plan in our time
7 left. But first I do want to ask you a couple
8 questions about page 13 of your report where you
9 talk about "PRINCIPLES GOVERNING EFFECTIVE
10 RESPONSE" --

11 A. Yes, ma'am.

12 Q. Okay. Here in this page of your report,
13 Doctor Alexander, you talk about certain
14 misconceptions. Do you see that?

15 A. Yes.

16 Q. Okay. And your Misconception #2, I think
17 you've said many times today, that "addiction,
18 rather an abuse, is the primary cause of
19 opioid-related morbidity and mortality." Is that
20 correct?

21 A. Yes.

22 Q. And then with respect to Misconception #3,
23 you talk about the misconception that "The epidemic
24 is largely driven by" "rogue physicians" with

1 "'doctor shoppers'" and in response, you say, "And
2 for example, "Rogue physicians," "while" "important
3 to identify and manage, account for a small
4 proportion of opioid-related harms."

5 Is that correct?

6 A. Yes.

7 Q. Okay. So in other words, it would be the
8 wrong focus to be looking at a group of physicians
9 who might be determined to be rogue physicians.
10 They have very little impact, in your opinion, on
11 opioid-related harms. Is that right?

12 MR. BURNETT: Objection, misconstrues
13 his testimony.

14 A. Yeah, it's not -- not correct. Because it
15 -- because -- I'm sorry, it's not correct because
16 there's not one singular focus. I mean, we -- we
17 can't have one focus if we're going to make headway
18 on this problem.

19 And so I would never want to suggest
20 that these individuals aren't important to
21 identify. I'm merely making the point here that
22 while they are very important to identify and
23 manage, they account for a small proportion of
24 opioid-related harms.

1 Q. Understood. And I wasn't suggesting
2 otherwise.

3 But while you might want to focus on a
4 list of particular physicians - and in your
5 opinion, it's important to identify these
6 physicians - that list or that group of physicians,
7 in your opinion, only accounts for a small
8 proportion of opioid-related harms.

9 Is that correct?

10 A. I -- in -- what I'm trying to do here is to
11 draw attention to the fact that I think we have --
12 historically, many individuals have erroneously
13 overemphasized the importance of devious
14 individuals, as I say, "such as rogue physicians
15 and patients who are 'doctor shoppers'" at the
16 expense of broader efforts to improve the quality
17 and scientific basis for opioid prescribing.

18 Q. So in other words, you're saying from your
19 perspective and your opinion, we shouldn't be just
20 focusing on a list of devious doctors or rogue
21 physicians; there are larger issues impacting
22 opioid-related harm. True?

23 A. Yes. We should not focus only -- and
24 frankly, it's not just physicians, right? Because

1 you know, up to a fifth of prescription medicines
2 are prescribed by nonphysicians, including opioids,
3 although I wouldn't want to go on the record
4 regarding a specific number.

5 But the point here is that, yes, I did
6 not believe that we should focus exclusively on
7 rogue prescribers.

8 Q. And that is because, in your opinion, they
9 would only account for a small proportion of
10 opioid-related harms. True?

11 A. I believe that that's the case, yes.

12 Q. Okay.

13 A. But -- I mean, "small" is -- you know, we
14 would have to quantify that, and that's part of a
15 longer conversation.

16 But yes, I believe that rogue
17 prescribers are very important and they have
18 contributed enormous harms. But relative to all
19 opioids prescribed and oversupplied, I believe that
20 rogue physicians are not the primary driver of
21 those behaviors.

22 Q. Now, on 15 of your report, page 15, this is
23 sort of a nice summary, the categories of your
24 abatement plan. Correct?

1 A. Yes.

2 Q. Okay. And Category 1, generally as we've
3 discussed a few times today, focuses on Prevention,
4 correct.

5 A. Yes. And it would helpful, if it's okay
6 with the videographer, if you could just display
7 whatever we're speaking to.

8 But I do have it in front of me, and
9 yes, Category 1 is Prevention.

10 Q. Sure. So why don't we go to - for the
11 record - Exhibit 4, let's go to page 16. And here
12 you write, Doctor Alexander, that the goal of this
13 part of your plan is to reduce what you say is a
14 "widespread oversupply of prescription opioids."
15 Correct?

16 A. Yes.

17 Q. Okay. Is there a current oversupply of
18 prescription opioids in Cabell County/Huntington?

19 A. Well, I believe the County is about twice
20 the national average, so, you know, I don't want to
21 draw conclusions about any particular patients'
22 care, but I certainly still have concerns that --
23 that many patients may be receiving these medicines
24 that -- where there's an unfavorable risk/benefit

1 balance, yes.

2 Q. Well, so -- again, I'll try my question
3 again. Do -- is it your opinion that there is a
4 current opioid prescription --

5 MS. GEIST: Strike that.

6 Q. Is it your opinion that there is a current
7 prescription opioid oversupply in Cabell County?

8 A. Yes, I think we still have a ways to go in
9 reducing the volume of opioids supplied in the
10 community.

11 Q. Okay. So can you tell me how much, what
12 percentage?

13 A. It's -- it's a great question, and it's one
14 I've been asked before. You know, what I can say
15 is that many patients -- is that we both have
16 underestimated the risks of opioids and we've
17 overestimated their benefits, and that many, many
18 patients receive opioids who would -- who would do
19 better with other products.

20 There's also a substantial population
21 of individuals - and I'm speaking generally here -
22 that are on chronic opioids that should be tapered
23 off of them. And I don't know whether other
24 experts have spoken in much more detail about these

1 matters. I did not do a detailed analysis of
2 individual patient record data from Cabell County
3 or the City of Huntington to estimate the quantity
4 of oversupply, and that's why I'm saying that --
5 that's why I'm inclined not to provide an exact
6 number.

7 One way to think of it is that if you
8 think about pre-epidemic levels -- setting aside
9 for a minute exactly when the epidemic began, but
10 let's say for -- for the purposes here, that the
11 epidemic began in the mid to -- mid to late 1990s.

12 If you think about the levels at that
13 time, I think that would provide one -- one
14 potential measure for what -- for what reasonable
15 levels at a population level might look like.

16 Q. But you can't tell me sitting here today
17 what percentage of the current supply of
18 prescription opioids in Cabell County would be a
19 correct or an appropriate percentage. Or what
20 percentage is too much. Is that correct?

21 A. I would --

22 MR. BURNETT: Objection.

23 A. I was not asked to develop that estimate.
24 I believe with time and the appropriate data, I

1 could probably do so. But I was not asked to do so
2 for this case.

3 Q. Well, to do so, Doctor Alexander, wouldn't
4 you need to look at every single individual
5 patient's records and all of the aspects of that
6 individual patient to determine whether or not the
7 prescribing doctor appropriately prescribed the
8 medication?

9 A. Well, what I --

10 Q. You -- you -- how can you -- can you make a
11 decision as to what is an appropriate number or
12 percentage of opioids without knowing everything
13 about the individual patients for whom these are
14 prescribed?

15 A. Well, I'm trained as a pharmaco-
16 epidemiologist, and my profession is exactly this,
17 which is the study of the use, safety and
18 prescription of medicines in large populations.

19 We never have the entirety of
20 information about an individual. There is always
21 more information that we would like than we have in
22 the databases that I use.

23 No study is -- is perfect in every
24 single way. And yet we are able to use

1 quantitative data from populations in order to
2 derive estimates such as the one that you're
3 inquiring about.

4 Q. Now, did you speak with any physicians in
5 Cabell County/Huntington who prescribe prescription
6 opioids and talk to them about why they're
7 prescribing and who their patients are?

8 A. There may have been -- I believe Doctor
9 Kilkenney's a medically-trained physician, and there
10 may well have been other clinicians that were on
11 one or more of the calls that I participated in.

12 But I did not conduct a study, if you
13 will, or sort of a -- I didn't perform what we
14 would call in -- professionally at Johns Hopkins,
15 key informant interviews.

16 I didn't do that sort of exploratory
17 research with -- with clinicians in Cabell County
18 and the City of Huntington. No, I did not.

19 Q. Did you -- well, you mentioned Doctor
20 Kilkenney. Did you speak with Doctor Kilkenney about
21 his prescriptions -- about his prescribing patterns
22 for prescription opioids?

23 A. I don't recall the details of the
24 conversation at that level. But I -- but one --

1 one question that invariably I ask people when I'm
2 speaking about local experts is what their sense of
3 the contours of the epidemic are, and -- and what
4 they think should be done and what they think is
5 most effective and what they think is less
6 effective and so on and so forth.

7 So -- but I don't recall the details
8 of my conversation with Doctor Kilkenny.

9 Q. Okay. And you cannot identify for me,
10 sitting here today, any other physicians who you
11 spoke with in Cabell County about their prescribing
12 decisions with respect to opioids. Is that true?

13 A. I believe that's true, that I did not have
14 those conversations. I think that some of these
15 matters may have been broached in some of the
16 materials that I reviewed, and if so, those are
17 materials that have been produced for the case.

18 Q. And sitting here today in terms of the
19 oversupply, you do not have an opinion as to
20 whether it's an oversupply by 5 percent, 10
21 percent, 20 percent, any specific percentage; is
22 that correct?

23 MR. BURNETT: Objection, asked and
24 answered.

1 Q. You just think it's just -- it's just too
2 much. Is that fair?

3 A. Well, I can do a little better than that, I
4 think, in terms of, again, trying to address the
5 spirit of your question.

6 And I already mentioned considering
7 pre-epidemic levels as one benchmark.

8 I also highlighted that I believe that
9 prescribing rates - while they have declined - in
10 the County and the City of Huntington - they're
11 still off the charts relative to national averages,
12 so I think that's a second perspective.

13 A third is a reminder - and I have
14 noted this previously, but I think it's important
15 to emphasize - that no single measure suffices to
16 understand and project the epidemic, no single
17 measure in and of itself.

18 And you recall the example with lung
19 cancer where if 100 people start smoking today,
20 they're not going to start dying from lung cancer
21 until many years out. So I have a little bit of
22 concern about using current levels of supply to
23 draw broad assessments regarding the -- the nature
24 of the epidemic.

1 But I think that we can reduce opioid
2 prescribing further within the County and the City
3 and do so safely and in a way that's concordant
4 with evidence-based medicine, and should it be
5 helpful for you or for plaintiffs or for the
6 courts, I'm happy to further opine on these
7 matters.

8 But it probably would take a further
9 investigation of -- of data as well.

10 Q. Now, but in -- in connection with your
11 opinions, I assume you didn't speak to any patients
12 who are currently being prescribed opioids by their
13 physicians in Cabell County. Correct?

14 A. That's correct, although I've spoken with
15 many, many patients, and many, many family members,
16 and many, many people who are bereaved because
17 their moms and dads, brothers and sisters and sons
18 and daughters have died. So -- and I also treat
19 patients --

20 Q. Let's --

21 A. -- so while --

22 Q. Let's go back to my question.

23 MR. BURNETT: Counsel, again, I
24 believe Doctor Alexander was not finished with his

1 answer.

2 MS. GEIST: We're in the last hour and
3 a half. My question -- we went through this
4 before, Counsel.

5 My question was simple. Did you speak
6 to any patients in Cabell County/Huntington who are
7 prescribed opioids by their physicians?

8 MR. BURNETT: And Counsel, you're not
9 entitled to interrupt the witness just because he
10 hasn't answered the question the way you want. I
11 would ask you to allow him to give a full answer,
12 and then you can ask follow-up.

13 MS. GEIST: He can answer "yes" or
14 "no" and then if he wants to expand on it --

15 Q. But it's a yes or no. Did you speak with
16 any patients in Cabell County of City of Huntington
17 who are currently being prescribed opioids by their
18 physician or health care provider?

19 MR. BURNETT: And Counsel, he was in
20 the process of answering the question, so you're
21 not being fair to the witness.

22 A. My concern about simply saying "no" is I
23 wouldn't want to misconstrue my knowledge of the
24 clinical dimensions of opioid prescribing, and so I

1 think it's important to highlight that while I did
2 not -- the answer is no, I did not speak with any
3 patients that I can recall from Cabell County or
4 the City of Huntington that are -- are receiving or
5 on long-term opioids, that I've spoken with many,
6 many patients and many, many family members, and
7 I've -- treat patients that have been on long-term
8 opioids.

9 So I just want to put on the record
10 that I have experience in this matter, even though
11 I may not have spoken with patients in Cabell
12 County and the City of Huntington.

13 Q. Okay. So just so I'm clear, you didn't
14 speak to any patients in Cabell County/City of
15 Huntington who are currently being prescribed
16 opioids, and you didn't speak to any physicians in
17 Cabell County/Huntington about their prescribing
18 habits with respect to opioids. That's true,
19 correct?

20 MR. BURNETT: Objection. Asked and
21 answered.

22 A. I mentioned that I have spoken with Doctor
23 Kilkenney, and I would just point to my previous
24 answers to your previous questions for further

1 information regarding this matter.

2 Q. That was it, Doctor Kilkenney. But you
3 don't recall sitting here today if you spoke with
4 him about his prescription patterns for opioids,
5 correct?

6 MR. BURNETT: Objection, asked and
7 answered.

8 A. This was a conversation that took place
9 perhaps six or nine months ago, and we spoke about
10 many different matters, and I don't recall the
11 details of the conversation at that level.

12 Q. Now, do you agree with me, Doctor
13 Alexander, as a physician, that the ultimate
14 decision to prescribe is based on risk/benefit
15 analysis and the individual patient factors that a
16 doctor or health care provider is considering?
17 True?

18 A. Well, I believe -- I mean, this is similar
19 to questions that I believe I've been asked
20 previously in a prior deposition, but -- but -- and
21 I think my answer then is the same as my answer
22 today, which is that ultimately, physicians or
23 other licensed prescribers may make decisions about
24 the use of a medicine, hopefully with patients, but

1 they, in turn, are informed by a great number of
2 other factors.

3 And so it's not so -- so it's not so
4 simple.

5 Q. Do you have any information in connection
6 with your opinion that there's an oversupply of
7 prescription opioids today -- do you have any
8 information about what percentage of the
9 prescription opioids being dispensed in Cabell
10 County/Huntington are for patients dealing with
11 cancer-related pain?

12 A. I wasn't asked to evaluate that.

13 Q. Do you have any information as to what
14 percentage of prescription opioids being dispensed
15 in Cabell County/Huntington to patients are to
16 treat arthritis or rheumatoid arthritis?

17 MR. BURNETT: Objection.

18 A. Which -- which one? Or both? Arthritis --

19 Q. I'll say -- well, do you have any
20 information whatsoever about what percentage of
21 prescription opioids that are being dispensed in
22 Cabell County/Huntington today are to treat
23 patients with rheumatoid arthritis?

24 MR. BURNETT: Objection.

1 A. I wasn't asked to evaluate that, nor did I
2 have data to do so.

3 Q. Did you have any information as to what
4 percentage of prescription opioids being dispensed
5 in Cabell County/Huntington today are for patients
6 with arthritis?

7 MR. BURNETT: Objection.

8 A. And do you mean degenerative joint disease
9 or what we call wear and tear arthritis, which is a
10 different disease than rheumatoid arthritis?

11 Q. I just said "arthritis" so --

12 A. Well, which type of arthritis are you
13 referring to?

14 Q. Let's say degenerative.

15 A. So opioids -- there are many patients that
16 are receiving opioids for arthritis who would do
17 better with alternative treatments that are safer
18 and more --

19 Q. That wasn't my -- that wasn't my question.
20 My question is: Do you know how many or what
21 percentage of patients in Cabell County/Huntington
22 are being dispensed, prescribed opioids for the
23 treatment of arthritis, degenerative arthritis?

24 MR. BURNETT: And I will note again

1 that you interrupted the witness.

2 A. I wasn't asked to provide such an estimate.

3 Q. Do you have any idea how many or what
4 percentage of patients in Cabell County/Huntington
5 are being dispensed prescription opioids to treat
6 musculoskeletal conditions?

7 MR. BURNETT: Objection.

8 A. Yeah, this wasn't -- this wasn't part of my
9 report. My report focused on evidence-based
10 methods to abate the epidemic.

11 Q. Now, in terms of your opinion with respect
12 to reducing what you have determined is an
13 oversupply of prescription opioids in Cabell
14 County/Huntington, you are not offering any opinion
15 that the distributors who are the defendants in
16 this case need to change or modify their business
17 practices. Is that correct?

18 A. I wasn't asked to opine on the role of --
19 of a specific party such as distributors.

20 Q. Do you know who the parties or the
21 defendants are in this case?

22 A. I believe I know the big three, at least.
23 I don't know if there are more.

24 Q. And just to confirm, Doctor Alexander, you

1 will not at the trial in this case be offering any
2 opinions specific to any of the three distributors
3 who are defendants here, namely AmerisourceBergen
4 Drug Corporation, McKesson and Cardinal Health?

5 A. Not unless -- not unless I was asked to do
6 so by the judge or, you know, the parties agreed
7 that I should do so. But that's not my current
8 understanding of the role that I would play.

9 Q. Okay. And you don't have any opinions of
10 that nature in your expert report that we've been
11 talking about today, correct?

12 A. Well, again, there's -- there's sort of the
13 technical term of art "legal opinion" and then
14 there's opinions. But in my report, I do discuss
15 oversupply, but I think that's as close as I get to
16 discussing the role of -- of potentially arguably
17 the role of distributors.

18 Q. Now, you also state that harm from
19 oversupply arises from diversion, diversion
20 throughout the supply chain. Is that correct?

21 A. Yes, it is, although if we're going to go
22 in detail here, it would be helpful for me if you
23 could project the page at which we are discussing.

24 Q. Well, I thought I was looking at it, and

1 I'm right. So it's right here, Doctor, on the
2 screen, page 16 --

3 A. Okay.

4 Q. -- first paragraph, you say, "Harm from
5 this oversupply arises from many points in the
6 continuum of care, ranging from how clinicians
7 treat pain to the diversion of opioids throughout
8 the supply chain."

9 Do you see that?

10 A. Yes, I do.

11 Q. Okay. That's what I'm referring to. If
12 there is diversion of prescription opioids
13 throughout the supply chain, who is doing the
14 diverting?

15 A. Well, many --

16 MR. BURNETT: Objection.

17 A. I mean, I wasn't asked to opine on -- on
18 the nature of drug diversion. What I can tell you
19 - and what we discussed briefly previously - is
20 that if you look at a population level at where
21 people say that they're getting their opioids who
22 are using them nonmedically, the vast majority say
23 either that they got them from a friend or family
24 member who, in turn, got them from a licensed

1 prescriber, or that they got them from a licensed
2 prescriber themselves.

3 But the broader point here is that
4 there is at least some level of diversion all the
5 way through the supply chain, so you can talk all
6 the way from drug warehouses to end users, and
7 there is some degree of diversion throughout the
8 supply chain.

9 Q. And you're not offering any expert opinions
10 with respect to diversion or the procedures in
11 place to prevent diversion, I assume. Correct?

12 A. Well, obliquely I speak to some of those
13 matters, for example, with the implementation of
14 safe storage and take-back programs. But I don't
15 directly speak to the role of distributors or
16 pharmacies or, you know, methods -- redesigning
17 work flow processes that could be used by those
18 parties so as to improve the safe distribution of
19 opioids.

20 Q. But certainly as you just acknowledged,
21 you're well aware that there is diversion of
22 prescription opioids by individuals who -- who
23 either steal them or get them from a friend or
24 family member, take them out of the medicine

1 cabinet and use them in a nonmedical way. Correct?

2 A. Yes.

3 Q. Now, we talked a little bit about the
4 programs and interventions already in Cabell
5 County/Huntington to address prevention, so I'm not
6 going to rehash a lot of that. Although just to
7 ask you quickly, are you familiar with the State
8 Prevention First program that's already in
9 existence in West Virginia?

10 A. The -- it's the State level primary
11 prevention program?

12 Q. Yeah, it's called Prevention First. It's a
13 -- literally, it's called Prevention First program
14 and it's in existence in West Virginia.

15 A. Yeah, I --

16 Q. Are you familiar with that program?

17 A. I believe that I considered or reviewed
18 information about it, but -- but I can't provide a
19 lot of additional detail about it.

20 Q. Can you tell me anything about what
21 Prevention First does and whether or not it's
22 available to Cabell County?

23 A. Well, there are literally --

24 MR. BURNETT: Objection.

1 A. There are literally dozens or hundreds of
2 different programs that have been deployed over
3 time in the City of Huntington and Cabell County
4 and in the State, and so you know, again, I -- I --
5 if this report is featured -- I'm sorry, if this
6 program is featured in the materials that I've
7 provided, then I reviewed it at some level of
8 detail.

9 But no, I can't speak to the way that
10 it may be currently deployed in the County.

11 Q. Do you know -- do you know to whom the
12 prevention or promotional campaign messages are
13 directed to by the Prevention First program?

14 A. Well, I'm aware that there have been
15 important social marketing campaigns and media
16 outreach that's been deployed in an effort to help
17 educate the general public regarding, you know, the
18 safe use and storage of opioids and principles of
19 sound pain management.

20 So I don't know if this is the program
21 that you're referring to, but --

22 Q. No, this program is actually directed
23 towards physicians.

24 A. Okay.

1 Q. Let's move on, though, and talk about pre
2 -- physicians -- you have a header, a specific
3 header, under Prevention where you talk about
4 Health Professional Education. And so the goal
5 here is "to train health care providers, including"
6 doctors "and other authorized health care"
7 providers who can write prescriptions for opioids.
8 Correct?

9 A. Yes, ma'am.

10 Q. And just by way of general purpose, through
11 this part of your plan, you're focusing on raising
12 awareness and disseminating information to the
13 medical community. Is that a fair
14 characterization?

15 A. Yes.

16 Q. Okay. And this, obviously -- when we're
17 talking about the medical community, we're talking
18 about Cabell County/City of Huntington, true?

19 A. Yes.

20 Q. Okay. Sitting here today, on September
21 18th, 2020, who in the medical community of Cabell
22 County/City of Huntington do you think does not
23 already know about the opioid epidemic?

24 A. Well --

1 MR. BURNETT: Objection.

2 A. I mean, everybody has -- my sense is, is
3 that everybody knows somebody that's been impacted.
4 But it's one thing to know that the house is on
5 fire, and it's another thing to know how to put it
6 out.

7 And so I think that there's enormous
8 headway that can be made in training individuals
9 and ensuring that they're up to date with the
10 latest science regarding prevention, treatment and
11 recovery.

12 So I think that virtually all
13 providers can benefit from additional opportunities
14 for training. There may -- it may be that it
15 shouldn't be one size fits all and that some
16 providers need a different type of training than
17 others, but I think that the vast majority of
18 providers in the community can benefit from an
19 opportunity to -- to learn more and to reflect and
20 to learn about programs and services that are
21 constantly changing and where there's sort of a
22 dynamic nature of that.

23 There's an ever-evolving evidence base
24 around treatments, and so I think there's lots --

1 you know, there's lots of providers, I think, can
2 benefit.

3 Q. And is it your opinion that today doctors
4 and health care providers in Cabell County/
5 Huntington are not already aware of the opioid
6 epidemic and the risk/benefit calculus that needs
7 to be undertaken in prescribing opioids, just like
8 with any other medication?

9 A. I was not asked to perform a comprehensive
10 needs assessment. But again, it's one thing to be
11 aware at a high level; and it's another thing to
12 really know state of the art evidence-based methods
13 of managing pain, to feel empowered, and to be
14 appropriately linked and to know how to utilize the
15 types of services and programs that we've discussed
16 together today.

17 I mean, this -- this abatement plan
18 won't work if there's not some training. And I'm
19 not naive enough to think that many of these
20 providers don't have a broad understanding of the
21 epidemic, but I think that the vast majority can
22 benefit extensively from opportunities for
23 additional training.

24 Q. Well, your goal of this aspect of your

1 abatement plan is to reduce oversupply through
2 reducing prescriptions. Isn't that your -- the
3 goal of your plan?

4 A. I mean, it's more than that. I mean,
5 that's important. But I'm sure that I discuss in
6 here - and I know elsewhere in the report, I
7 discuss - that it's not just about reducing
8 oversupply. I mean, that's very important. But we
9 need to do it -- but you can't just ratchet down
10 opioids.

11 You have to understand evidence-based
12 pain treatment. You can't just focus on pain
13 treatment. You have to identify opioid use
14 disorder. You can't just identify opioid use
15 disorder; you have to be able to screen in a
16 sensitive matter -- manner for things like intimate
17 partner violence and posttraumatic stress disorder.

18 So it's not -- so it's not -- my point
19 is it's not just about training docs and other
20 prescribers to ratchet down the opioids.

21 Q. Now, as part of your plan, you suggest that
22 the focus should be on top prescribers, whether
23 those are physicians, dentists, nurse practitioners
24 or P.A.'s, correct?

1 A. Yes.

2 Q. And that these academic detailers, as I
3 think you refer to them, should meet with these top
4 prescribers four times a year. Is that right?

5 A. Yes.

6 Q. And this assumes, of course, that these top
7 prescribers are not already fully aware of the
8 opioid epidemic and the risk/benefit profile of
9 prescription opioids. Correct?

10 A. To -- may I --

11 MR. BURNETT: Objection.

12 A. -- ask to pause for one minute, please?

13 Q. Yes. Do you need to take a call or
14 something?

15 A. No, no, thank you. I just would like to
16 review. Because in this section, I believe that
17 there is more content regarding the -- the -- sort
18 of the comprehensive nature of the training that I
19 propose, and so I just wondered -- I mean, so for
20 example, in Paragraph 51, I talk about "hospitals,
21 health systems, integrated delivery networks,"
22 "should work diligently to incorporate programming
23 and professional development to raise awareness and
24 knowledge regarding drivers of the epidemic."

1 Q. Right. But I'm -- I understand that,
2 Doctor Alexander, and there's a lot of paragraphs
3 here in this section of your plan.

4 A. I know.

5 Q. But what I'm asking you about specifically
6 is about the academic detailers that you are
7 suggesting --

8 A. Yeah.

9 Q. -- be deployed to speak to top prescribers
10 four times a year.

11 A. Right, right. That's fine. That's fine.
12 That's fine. I just wanted to call out that in
13 Paragraph 40, I discuss that efforts to reduce
14 oversupply should be coupled with information
15 regarding the principles of sound pain management,
16 comprehensive assessments and so on and so forth.

17 I'm sorry, but I just wanted to be
18 sure that I made clear that it's not just about
19 ratcheting down prescribing.

20 So yes, academic detailing is a
21 program that I propose and I believe should be
22 targeted to the highest volume prescribers with
23 outreach four times a year.

24 Q. So is it possible that the highest

1 prescribers in the region are fully informed and
2 are already aware of the risk/benefit profile of
3 prescription opioids and of alternative treatments
4 to patients with pain?

5 MR. BURNETT: Objection.

6 A. That's something that the academic
7 detailers could -- could -- could evaluate and
8 could discuss with the prescribers.

9 Q. Now, in terms of your population to which
10 the academic detailing would be focused and the
11 cost, it looks to me from reviewing your - sorry -
12 redress model for health professional education,
13 you don't have a cost estimate. Is that right?

14 A. I would like to look at the redress model.

15 Q. Yeah, you can. We marked it. It's Exhibit
16 7.

17 MR. BURNETT: Counsel, I don't think
18 we did mark it. Exhibit 7 is just Appendix C.
19 It's a one -- you know, a front and a back of one
20 document. It's just --

21 MS. GEIST: There is -- I'm sorry,
22 Counsel, or Doctor Alexander.

23 Is there a tab like 7.1 or something
24 like that?

1 A. Yes, there is.

2 Q. Okay, that's where it is. I apologize.

3 ALEXANDER DEPOSITION EXHIBIT NO. 7.1

4 (Alexander Appendix D - Redress Model
5 FINAL was marked for identification
6 purposes as Alexander Deposition
7 Exhibit No. 7.1.)

8 VIDEO TECH: Exhibit 7.1 has been
9 marked on Exhibit Share.

10 MS. GEIST: Thank you, John.

11 A. Okay, I have Tab 1A available from Exhibit
12 7.1.

13 Q. Great. Okay. So just for the record,
14 Doctor Alexander, this is Exhibit 7.1. It is your
15 redress model, with the population inputs that you
16 had included with your expert report. Does this
17 look -- is this familiar to you?

18 A. Yes, although I believe an errata or
19 addendum was provided, but I don't think it's
20 germane to the matter at hand, professional
21 education.

22 Q. Okay. And yes, we do have your errata,
23 thank you. But I didn't mark it for purposes of
24 these questions.

1 So in terms of the academic detailing
2 that you're proposing, you have a certain number of
3 prescribers?

4 A. Yes, ma'am.

5 Q. Okay. And it indicates to me - looking at
6 this section of the redress model - that you are
7 assuming an increase in the number of prescribers
8 every year from 2021 through 20 -- well, from 2021
9 through 2035.

10 A. Yes, ma'am.

11 Q. And for this population estimate, did you
12 utilize any data specific to Cabell County/
13 Huntington, or is this West Virginia statewide
14 data?

15 A. Well, the source of the information is from
16 -- is provided on Line 20, and so this was 2017
17 data from HRSA, essentially.

18 And I believe that it's county-
19 specific.

20 Q. Okay. You can put this aside. The
21 academic detailing that you are suggesting to
22 prescribers, you indicate again that that is to
23 educate them and train them on the appropriate use
24 of opioids in their clinical practice. True?

1 A. Yes.

2 Q. So it assumes, does it not, that the top
3 prescribers that you indicate should be targeted
4 for this detailing four times a year do not
5 understand the appropriate use of opioids in their
6 practice. It assumes that, does it not? It
7 assumes they need to be educated and they don't
8 understand how to appropriately prescribe opioids.
9 True?

10 MR. BURNETT: Objection, asked and
11 answered.

12 A. I mean, it provides -- it's a reasonable
13 place -- if you're gonna -- if you're gonna reach
14 out and try to identify the potential oversupply,
15 continuing oversupply, of opioids, it's a
16 reasonable approach, I believe, in my professional
17 experience, to target individuals for that outreach
18 that are at the top of the pyramid.

19 And some of them may be prescribing --
20 I mean, some of them may be prescribing more
21 appropriately than others; and -- and resources
22 notwithstanding, one could use local data to design
23 a different approach. In other words, it might be
24 that one of these doctors is a hospice doctor.

1 Now, it just so happens that opioids
2 are actually overprescribed, many would argue - and
3 some studies suggest - even in hospice, but say if
4 one of the doctors was a hospice doctor, you could
5 decide not to reach out to her, or you could derive
6 another approach.

7 But I think this is a reasonable
8 approach. But I'm not suggesting that all of these
9 doctors that would be targeted for outreach are
10 doing something wrong or should necessarily change
11 their behavior.

12 Q. Okay. Well, then you agree with me that in
13 fact it could be the case that every single one of
14 these top prescribers that you would target for
15 academic detailing may be fully informed as to the
16 risk/benefit calculus involved in any prescription
17 of opioids for their patients, especially sitting
18 here in September of 2020, you would agree with me
19 that that is certainly a possibility.

20 Correct, Doctor?

21 A. I think it would be highly unlikely in my
22 professional judgment.

23 Q. But you don't know, sitting here, either
24 way. True?

1 MR. BURNETT: Objection, asked and
2 answered.

3 A. Yeah, I wasn't asked to perform a quality
4 evaluation of the current prescribing patterns of
5 -- of prescribers in Cabell County and the City of
6 Huntington.

7 Q. You know, Doctor, that we are, I think,
8 four years now past the CDC's guidelines with
9 respect to the prescription of opioids. Correct?

10 A. Yes, ma'am.

11 Q. You're very familiar with those guidelines,
12 true?

13 A. I have working experience with them, yes.

14 Q. Okay. And West Virginia, as a state, has
15 put forward different guidelines to the physician
16 community through the State Medical Board. True?

17 A. Yes, I believe that's the case.

18 Q. And you're familiar with all of that,
19 right?

20 A. Yes. Again, with varying levels of
21 familiarity. But I think virtually every state in
22 the country has worked to try to institute
23 guidelines to promote more evidence-based opioid
24 use.

1 Q. What -- and of course, I'm sure you're
2 familiar because you have it in your report, the
3 PDMP program in West Virginia, I think it's -- the
4 specific acronym is the CSMP, and that's the Board
5 of Pharmacy's Controlled Substance Monitoring
6 Program. That has been in place and required to be
7 used now by physicians and pharmacists for some
8 time. True?

9 A. Yes, I believe so.

10 Q. What can you tell me about the
11 physician education that has gone on in the state
12 of West Virginia and in Cabell County specifically
13 with respect to the appropriate prescribing of
14 opioids for their patients?

15 MR. BURNETT: Objection.

16 Q. Other than what I just listed.

17 A. Again, I did not perform a comprehensive
18 evaluation of programs to date, but what I would
19 say is that in virtually every part of the country,
20 there is value in further investments being made in
21 educating clinicians regarding not just the
22 appropriate use of opioids - although that's
23 important - but also the principles of sound pain
24 management and also the identification and

1 treatment of people with opioid addiction.

2 I mean, keep in mind, you know,
3 anywhere from 8 to 10 percent or 8 to 9 percent of
4 the County is estimated to have opioid use
5 disorder.

6 So this isn't just about -- this isn't
7 just about improving the treatment of people with
8 pain; it's also about better identifying and
9 treating those with opioid use disorder.

10 Q. Now, you agree with me, I assume, Doctor
11 Alexander, that there is already courses offered
12 regarding the appropriate prescription of opioids
13 from or through the West Virginia Board of
14 Medicine. Correct?

15 A. I believe there's educational outreach. I
16 don't know the details of the curricular offerings.

17 Q. And Marshall -- so you don't know what type
18 of CMEs or other educational programs the West
19 Virginia Board of Medicine has offered and is
20 offering to its -- to its physician community for
21 the appropriate prescription of opioids?

22 MR. BURNETT: Objection.

23 A. Again, I -- I don't know the details of --
24 of sort of the number of hours or the -- the -- you

1 know, the -- the core curriculum or the
2 competencies and the like. But I am aware that
3 there is educational outreach such as online
4 courses that clinicians can take in order to better
5 stay abreast of the principles of sound pain
6 management and opioid use.

7 Q. Are you aware that Project Engage also has
8 a component of that program that is designed to
9 educate the physician and prescribing community as
10 to the appropriate way to prescribe opioids?

11 A. Yes, I believe so.

12 Q. And there's also grand rounds available at
13 Marshall University on these topics, correct?

14 A. Yeah, that -- that may be the case. I
15 mean, grand rounds is, you know, not likely to sort
16 of change everyone's behavior, but it's one
17 important piece of the puzzle.

18 Q. Are you familiar with any information that
19 has come out of the West Virginia Office of
20 Attorney General designed for physicians?

21 MR. BURNETT: Objection.

22 A. You're asking whether I'm aware of
23 programming for clinicians that has been produced
24 by the Attorneys General of West Virginia?

1 Q. Yeah, I'm asking you -- I mean, we're
2 talking about your program that you were
3 proposing --

4 A. Right.

5 Q. -- to address health care provider
6 education --

7 A. Yeah.

8 Q. -- and I'm asking you, are you aware if
9 there is any communication tools or information
10 tools that have come out of the West Virginia
11 office of The Attorney General --

12 A. Right.

13 Q. -- to physicians.

14 A. Right. I'm not aware of that. And it may
15 well be that there are such programs. I think one
16 of the important things that I suggest in my plan
17 is -- is to use evidence-based outreach; in other
18 words, to use opioid prescribing as a means to
19 identify and target specific prescribers.

20 And another thing that I'll note is
21 that a lot of this conversation has been about
22 physicians, but physicians are just one type of
23 health care personnel who is so important to reach
24 in educational outreach.

1 So I think, you know, it's also
2 important to be considering EMTs, nurses,
3 physician's assistants, dentists, allied healthcare
4 professionals and the like.

5 Q. What about the Mayor's Office of Drug
6 Control Policy? Have they also been involved in
7 providing education and other materials to
8 prescribers in Cabell County?

9 A. I think that they have. Again, I would
10 want to review materials more carefully with you in
11 order to go into detail. But you know, one of the
12 things that we haven't discussed today and that I
13 think is important to consider is the ways that
14 programs are assessed and quantitatively evaluated
15 over time.

16 And you've asked me about how -- what
17 I thought about City of Solutions and what I think
18 about various programs. I've spoken to that. But
19 the idea behind academic detailing - which is one
20 of the core components of this Category 1A - the
21 idea is that we actually use data to have a
22 data-informed outreach to specific prescribers.

23 Q. Now, one of the things you suggest as part
24 of your plan is -- or you raise the National

1 Resource Center for Academic Detailing. I guess
2 it's NRCAD, and that's at Paragraph 47 --

3 A. Yes.

4 Q. -- of your report.

5 A. Yes.

6 Q. And that -- that academic detailing group
7 has already partnered in West Virginia and
8 specifically in -- in the region; isn't that true?

9 A. Yes.

10 Q. Okay. Now, with respect to the -- the
11 CSMP, that is the database that is now required to
12 be accessed by both physicians and pharmacists
13 before prescribing medication to ensure that
14 there's not doctor shopping and things of that
15 nature, and you're aware of that, right, Doctor
16 Alexander?

17 A. Yeah. I mean, I -- I think there are
18 contexts in which it's to be used. I'm not sure
19 it's to be used in every single instance, but I am
20 aware of the general role of PDMPs, including West
21 Virginia's PDMP and the efforts to use that to try
22 to promote safer opioid use.

23 Q. Now, do you agree -- well, do you agree
24 with me or do you know whether the CSMP is

1 accessible to distributors?

2 A. I'm not aware of whether or not
3 distributors use this resource.

4 Q. Okay. And do you agree with me if a
5 pharmacist checks this database source, the CSMP,
6 and has a concern on the pharmacist's part about
7 the prescription, prior to dispensing to that
8 patient, the pharmacist should raise the concern
9 with the doctor. True?

10 A. Well, I wasn't asked to opine on the use of
11 the PDMP by pharmacists per se, but I think that
12 pharmacists play an important role in addressing
13 the -- the opioid epidemic.

14 I'm sorry, if you can ask the question
15 again, I can try to answer more directly.

16 Q. Sure. You have -- you have some
17 information in your report about the PDMP in West
18 Virginia, which is the CSMP, correct?

19 A. Yes.

20 THE DEPONENT: Although it would be
21 helpful, Jonathan, if you can show the paragraph
22 that we're discussing.

23 MS. GEIST: It's Paragraph 43.

24 A. Okay, thank you.

1 Q. And here you write, "Since academic
2 detailing should target vie volume prescribers in
3 the Community, it must be based on information
4 regarding specific individuals' prescribing
5 behaviors." And "One source of such information"
6 is the "(CSMP)."

7 A. Right, thank you.

8 Q. Did you review and research and ensure that
9 you understood the CSMP when you included this in
10 your report?

11 A. Absolutely, of course. I mean, the
12 reference -- I think Reference 152, in particular,
13 would be the first that I would point to if we were
14 to explore this further.

15 Q. Okay. And then so you would agree with me,
16 I assume, from your research and review that the
17 CSMP, the database of information, is not available
18 to distributors. True?

19 A. Again, I think you asked me that question,
20 but I wasn't -- I'm not familiar with whether or
21 not distributors use or access the CSMP.

22 Q. Okay. Fair enough. Question, though, with
23 respect to the role of pharmacists here, because
24 you did say pharmacists play an important role. Is

1 that correct?

2 A. Yes, among many other stakeholders,
3 absolutely.

4 Q. Okay. But I assume you would agree with me
5 as a practicing physician, that the decision
6 whether to prescribe prescription opioids in the
7 first instance, that decision is solely within the
8 discretion of the doctor or health care provider
9 who is authorized to prescribe such medication.
10 True?

11 MR. BURNETT: Objection, asked and
12 answered.

13 A. Yeah, I believe we discussed that before.

14 But it's the provider or the
15 prescriber - as I said before - hopefully, and in
16 many cases, the patient, reaching shared decisions,
17 and they, in turn, are influenced by any number of
18 other factors.

19 Q. So let me try my question again, because I
20 don't think I asked you and I don't think you
21 answered it.

22 A. Okay.

23 Q. In terms of the role of the pharmacist, the
24 pharmacist does not play a role in deciding whether

1 or not a prescription opioid should be prescribed
2 in the first instance. That is solely within the
3 responsibilities of the physician or other health
4 care provider who has authority and license to
5 prescribe. True?

6 A. And my response was that it's the
7 prescriber and the patient, so I don't think it's
8 just the prescriber. I think the patient, in many
9 cases, shares a decision and I just wanted to be
10 sure that I'm clear that they, in turn, can be
11 influenced by a number of other factors.

12 But yes, the pharmacist does not -- is
13 not involved in that initial decision. I would
14 agree with that.

15 Q. Now, you reference here, I think on this
16 same page, Doctor Alexander, page 18, the CDC
17 guidelines that we discussed earlier from 2016, the
18 "Guideline for Prescribing Opioids For Chronic
19 Pain." Do you see that?

20 A. Yes, ma'am.

21 Q. Okay. And you have that as a footnote.
22 Are you -- and you write here - if I can find it.
23 There it is, I apologize. Paragraph 44, you note
24 that the CDC guidelines from 2016 referring to

1 prescribing opioids for chronic pain, that these
2 guidelines have received widespread endorsement.

3 Do you see that in the middle of the
4 paragraph there?

5 A. Yes.

6 Q. And then your recommendation is that the
7 "Guideline" should "be cross-referenced with other
8 guidelines and sources used by established provider
9 education programs already underway on opioids."

10 Did I read that correctly?

11 A. Yes, and then I would just draw your
12 attention to Footnote N where I qualify the use of
13 the guidelines.

14 Q. Correct. You say at the bottom, the
15 guideline "is" "comprehensive, authoritative" and
16 "widely cited," and "any" "detailing program as
17 part of an abatement remedy should be based on an
18 assessment of the current and suitable sources of
19 information for such a program." Correct?

20 A. Yes.

21 Q. Okay. Well, my question is: You note that
22 the guidelines from the CDC obtained widespread
23 endorsement. Are you aware that the American
24 Medical Association came out in response to the

1 guidelines, raising issues relating to patient harm
2 -- unintentional patient harm as a result of the
3 guidelines that were put in place by the CDC in
4 2016?

5 A. I'm not aware that the AMA did; but I know
6 that there has been pushback against the
7 guidelines, and in fact, I've done some empiric
8 work looking at that.

9 Q. Okay. So you are aware that there is at
10 least some aspect of the medical community that did
11 not - and has not - widely endorsed the CDC
12 guidelines from 2016, correct?

13 A. I would characterize it slightly
14 differently. I think the majority of concern has
15 been around how the guidelines have been
16 interpreted or implemented rather than the science
17 of the guidelines themselves.

18 I'm not aware of authoritative
19 substantive widespread concern about the substance
20 of the guidelines.

21 Q. But you're not aware of -- and you did not
22 read, I assume, the letter that was put out by the
23 American Medical Association in response to the
24 guidelines. Is that correct?

1 A. I don't recall if I read that letter or
2 not. But what I can tell you is that there was
3 enormous pushback to these guidelines, and in fact,
4 we published a paper examining the sources of such
5 pushback, and I believe I referenced that as one of
6 the publications in this report.

7 So I don't want to go back a rabbit
8 hole, but I'll just say that -- that, you know, the
9 guidelines came out at a time when there was a lot
10 of misconceptions around the role that opioids
11 should play in the treatment of chronic noncancer
12 pain, and unfortunately, some of those
13 misconceptions persist.

14 Again, I think the majority of the
15 opposition to the guidelines has been based on how
16 they've been implemented, not -- not sort of
17 concern about the guidelines themselves.

18 Q. Do you agree that as a results of the
19 guidelines or the implementation of the guidelines
20 that there has been - and perhaps inadvertently so
21 - harm to certain patients?

22 A. I have yet to see very well done rigorous
23 evaluations quantifying the unintended effects of
24 these guidelines. And I can tell you that I have

1 -- you know, I have seen anecdotes of people, for
2 example, committing suicide - which would be a
3 horrific consequence - but I've not seen
4 substantive scholarship that has carefully
5 enumerated the unintended consequences of these
6 guidelines.

7 I think the very important clinical
8 matter and very important public health matter, but
9 again, I think the majority of the concern around
10 the guidelines has been - just to be more concrete
11 and put a sharper point on this - the issue, for
12 example, of opioid tapering and discontinuation,
13 and I speak to that in my report, and there is an
14 art and a science to that.

15 And there are evidence-based
16 strategies that we can use to reduce the oversupply
17 of opioids and the continued overreliance on
18 opioids and, simultaneously, improve quality of
19 care for those with pain.

20 There's no contest here.

21 Q. Sorry --

22 A. There's no --

23 Q. Sorry, I thought you were done.

24 A. I could be done. I'm done.

1 Q. Okay. I just wanted to ask you a couple
2 quick follow-ups.

3 A. Okay.

4 Q. You agree with me that not every patient
5 who is using prescription opioids needs to be
6 tapered off. True?

7 A. I agree that there are some patients that
8 can be maintained safely and with clinical benefit
9 on -- on long-term opioids. But it depends.

10 Q. But they are not -- you are not suggesting
11 or opining that prescription opioids be removed
12 from the market or that they do not have an
13 appropriate place in terms of options for
14 physicians to use with their patients with pain.
15 You're not suggesting any of that. True?

16 A. I'm not suggesting that they should be
17 removed from the market. And I think I may have
18 used this example previously, but prescription
19 drugs aren't inherently good or bad any more so
20 than a role of duct tape or a hammer or a razor
21 blade is good or bad.

22 The value of a drug depends upon how
23 it's used. And the concern with opioids is that
24 they've been vastly oversupplied in many contexts,

1 and we're paying the price many years later.

2 Q. I think a few years ago, there was a rally
3 in Washington, D.C. - was it called Fed Up - and
4 you spoke at that rally, didn't you, Doctor
5 Alexander?

6 A. I did.

7 Q. And I watched the YouTube video, with
8 interest, but one of the things that struck me is
9 part of your speech really was a criticism of the
10 -- of the health care system generally and the
11 coverage provided for alternative pain medications.
12 Is that correct -- al pain -- alternative pain
13 modalities or treatments.

14 Is that correct?

15 A. I don't recall the details of the -- of my
16 comments. It was many years ago.

17 Q. Well, today, sitting here today, do you
18 agree that there should be changes, revisions to
19 the health care system to allow for insurance
20 coverage for nonmedication-related pain modalities?

21 A. I believe I addressed this in my report,
22 and I say that this is out of scope. In other
23 words, I don't consider coverage and reimbursement
24 considerations, but I think it -- it should be part

1 of a broader conversation.

2 Q. Now, you said earlier when we were talking
3 about unintentional harm to patients as a result of
4 the implementation of the CDC guidelines, you --
5 there has not been - from your perspective - a
6 well-designed robust study looking at that in the
7 literature.

8 Is that what you said more or less?

9 A. More or less. I'm not aware -- I'm not
10 aware of -- of well done, carefully designed
11 scientific studies quantifying the unintended
12 consequences of the CDC's guidelines.

13 Q. But you -- so there's not scientific well
14 designed studies quantifying the harm to patients,
15 but based on your reference, you know - and have
16 heard, as a physician - that patients have in fact
17 been harmed.

18 And I think you even mentioned that
19 some patients have committed suicide after their
20 prescription opioids were removed. Is that right?

21 A. No. No. That was a lot, and I'd like to
22 unpack it. But you -- first of all, you used the
23 word "reference." Which reference are you
24 referring to?

1 Q. I'm not sure which reference you're
2 referring to. So let me start again. Before you
3 mentioned that you had heard anecdotally that there
4 were cases of suicide by patients suffering
5 enduring pain who had their prescription opioids
6 removed from them as a result of the implementation
7 of the CDC guidelines. True?

8 MR. BURNETT: Objection.

9 A. No. No. I have no idea -- I -- this is --
10 so this is anecdote. I don't know if it's
11 pertaining or related to the CDC guidelines. And
12 speaking of information about -- speaking of
13 clinical information about individual cases, I have
14 no clinical information about this particular
15 instance.

16 And so you know, in -- I mean, there
17 are so many different levels at which you could
18 raise concern about drawing causal inference from
19 that type of anecdote, and -- and sort of reaching
20 some attribution or conclusion about a guideline
21 based on that.

22 So I just -- it's -- it's -- I would
23 not want to misconstrue what I said. What I said -
24 or what I intended to say - was that I'm aware that

1 there has been pushback against the CDC guidelines;
2 that I believe the majority of the pushback is
3 focused on its implementation rather than the
4 science that it contains; and that I've not seen
5 rigorous scholarship that has evaluated --

6 I'm not aware of rigorous scholarship
7 that's evaluated unintended consequences of the
8 guidelines, although such scholarship may exist.

9 And lastly, that -- that I've heard of
10 anecdote of individual -- of an individual or
11 individuals that have committed suicide because
12 they were un -- because of their poor pain control.

13 But I know nothing about, you know,
14 the -- the clinical context, whether it was an
15 accidental death or not, the degree to which the
16 patient had depression or mental illness, the
17 degree to which opioids were or were not an
18 important feature of the suicide, and so on and so
19 forth.

20 So I just think that's important to
21 clarify.

22 Q. So let's move on to Patient and Public
23 Education, talking about --

24 MR. BURNETT: Counsel, yeah, before we

1 do that, we've been going an hour and 15, and we
2 have less than an hour of testimony left. Can we
3 take a break?

4 MS. GEIST: Yeah, absolutely.

5 VIDEO OPERATOR: The time is 5:16. We
6 are now going off the record.

7 (A recess was taken after which the
8 proceedings continued as follows:)

9 VIDEO OPERATOR: The time is 5:32, we
10 are now back on the record.

11 BY MS. GEIST:

12 Q. Doctor Alexander, we are now going to move
13 to the section of your report that addresses
14 Patient and Public Education, and that starts on
15 page 22 of your report.

16 A. Yes, ma'am.

17 Q. And here, it appears --

18 MS. GEIST: Thank you.

19 Q. Here, it appears that you are suggesting -
20 among other interventions and programs - that there
21 be a mass media campaign directed towards patient
22 and public education; and in particular, younger
23 individuals. Is that a fair summary?

24 A. Yes, I mean, this is focused on all

1 individuals, not just younger ones. But yes. And
2 if --

3 MS. GEIST: We need to go to page 22.

4 A. Yeah, that's right.

5 MS. GEIST: Sorry, that's my bad.

6 Page 22, John. I'm sorry.

7 Q. Okay. So again, though, Doctor Alexander,
8 we're sitting here in September 2020. You are
9 proposing this as a future intervention or future
10 programs. This assumes that individuals in Cabell
11 County/Huntington - because that is what we're
12 talking about - are not aware of the potential
13 risks of using opioids, whether they're
14 prescription or illicit.

15 MR. BURNETT: Objection.

16 Q. I mean, is it your opinion that the people
17 of Cabell County/Huntington are not aware that
18 there are risks associated with the use of
19 prescription opioids and illicit opioids?

20 A. Well, I didn't perform any comprehensive
21 needs assessment or, you know, survey or anything
22 else of -- of the County's residents or the City's
23 residents, but I think you have to include some --
24 some measure of patient and public education if an

1 abatement program is going to be successful.

2 And what I've proposed builds upon --
3 and I call out examples of other programs - for
4 example, in Paragraph 55 here - as I -- as I
5 suggest the importance of these interventions.

6 Q. You would agree with me that as part of the
7 CDC 2016 guidelines, that is a reiteration, if you
8 will, that doctors need to speak with their
9 patients about the risk/benefit profile of
10 prescription opioids. That's in the guidelines,
11 correct?

12 A. Yes, I believe it is.

13 Q. And are you aware that in 2017, the CDC
14 conducted a mass media campaign -- campaign itself,
15 and it was specifically implemented in the state of
16 West Virginia?

17 A. Yes, I am.

18 Q. And that was specific as to opioids.
19 Correct?

20 A. I believe so. I don't recall for sure, but
21 I believe so.

22 Q. And are you also aware that there are other
23 programs such as Hope and Hope West Virginia,
24 Stigma Free West Virginia and a media campaign

1 through Healthy Connections, all towards the goal
2 of creating information and education about
3 addiction generally and hoping to reduce the stigma
4 of individuals who may want help for their
5 addiction?

6 A. I am. And these programs are important,
7 but it's worth noting that over the past 20 years,
8 if you view the epidemic and sort of take a 36,000
9 foot view, there have been many different programs
10 that have been deployed at different stages, and --
11 you know, and yet things have gotten worse rather
12 than better.

13 So I -- what -- and that's the basis
14 for the comprehensive program that I propose. So
15 it's certainly the case that there are -- in this
16 instance, that there are other public and --
17 patient and public education campaigns that have
18 been conducted thus far.

19 And what I propose to do is to build
20 upon those and to make sure that it's well
21 integrated with other interventions that I
22 describe.

23 Q. So in other words, you agree with me, all
24 of this public and patient information,

1 communication, education, it's all in place; it's
2 all been done. But you think there essentially
3 needs to be more to do. Is that fair?

4 A. Well, I think --

5 MR. BURNETT: Objection. Objection,
6 mischaracterizes the testimony.

7 A. I mean, I think -- as I've -- as I've
8 commented regarding other programs, it's not as
9 simple as just saying, "Well, we've got a program
10 to address that" or "I've got a policy for that."

11 So we can ask questions. If it's
12 about public and patient education, we can ask
13 questions like -- so it's -- take a tool kit, okay?
14 A tool kit sounds great. Let's design a tool kit.
15 Who's using the tool kit? How many people have
16 been reached with it? How extensive was the
17 outreach?

18 Was it followed up over time? How
19 well were the messages that were incorporated into
20 the tool kit designed? Did they use principles of
21 good social market? And so on and so forth.

22 So it's not just as simple as, you
23 know, "We've got -- we've got a campaign and so
24 we're done" and "We've got a kid -- a place for

1 children that are orphaned and we're done with that
2 one too."

3 There's nuance to this, and these
4 programs need resources and they need -- they need
5 scientific foundations, and they need investments
6 over time, and they need leadership, among other
7 things.

8 Q. Now, in terms of your -- your cost estimate
9 for the mass media campaign that you're proposing,
10 if we look at this section of your redress plan --
11 or your redress model - I apologize - it appear --

12 I'll wait for you to get there, Doctor
13 Alexander.

14 A. Well, I'm looking at Tab 1B of Tab 7.1 --

15 Q. Okay.

16 A. I'm looking at the Excel sheet. But maybe
17 that's not the right place to look. But that does
18 include information on -- so it's Tab 1B. That's
19 where, I believe, we're talking about here.

20 Q. Okay. And your cost estimate for the mass
21 media campaign that you are suggesting be
22 implemented in Cabell County and the City of
23 Huntington is based on The Real Cost campaign; is
24 that correct?

1 A. Yes, ma'am.

2 Q. And that is a national -- or was a national
3 tobacco education plan designed to prevent
4 teenagers, essentially, from beginning cigarette
5 smoking. Correct?

6 A. Yeah, it is.

7 Q. Okay. Well, what -- it appears that you
8 looked at annual costs of this national program
9 that was put in place some years ago and you've
10 also looked at average costs per month? Is that
11 correct?

12 A. Yes.

13 Q. Okay. Well, what -- what adjustments did
14 you make to account for the fact that this is --
15 this is not a national program that you would be
16 suggesting; it would be a program targeted at the
17 public and patients in Cabell County, West
18 Virginia.

19 A. That's a great question. So one thing I
20 want to note about my cost estimates, is that --
21 well, there's -- there's a reason that we chose --
22 and that I used this campaign as a means to cost
23 out this program.

24 So I'm happy to come to that, if

1 that's helpful. But you asked specifically -- you
2 pointed out that this is a national campaign, and
3 yet we're talking about Cabell County and the City
4 of Huntington, West Virginia.

5 And what we do here is: We look at
6 the cost essentially per capita. And so if you --

7 THE DEPONENT: Jonathan, if you can
8 scroll up so that we can review the top of the
9 spreadsheet as well -- maybe at the same time --
10 maybe it's not possible.

11 A. But in any case, we look at the cost per
12 capita, and so the ultimate cost per capita is 38
13 cents per month per the target population, and I
14 multiply that out by 12 months. So that's how we
15 derive an estimate that's customized for the target
16 population here, which is the number of individuals
17 in Cabell County age 12 years or older, or about
18 89,600 individuals.

19 Q. Now, the national campaign, though, of
20 course, appeared on national television, national
21 television channels, correct?

22 A. I believe it did.

23 Q. I'm looking at your -- at the bottom there
24 under Suggested Costs?

1 A. Right.

2 Q. This program would not need to be put on
3 national television programs. True?

4 A. Yes, that's true.

5 Q. And there's no magazines specific to Cabell
6 County/Huntington, I assume, correct?

7 A. Well, there may well be periodicals or
8 local circulars. I don't know.

9 Q. Do you know how many movie theaters are in
10 Cabell County/City of Huntington?

11 A. I don't. But these estimates, I'd like to
12 add, are based on a careful and comprehensive
13 review of a number of different sources for any
14 estimate that's included in my redress models, and
15 so I just want to use this point -- or this
16 opportunity to make clear that in all cases, I
17 carefully considered a number of different sources
18 of information.

19 I tried to use local sources whenever
20 they were available, and when they were not
21 available or when I had concerns about the
22 scientific validity of a local source, I would use
23 a regional or national source.

24 There were some instances where there

1 were multiple estimates, and in those cases, I
2 either took an average or I conservatively took the
3 lower number of two or more estimates that might be
4 available, so I just want to say that there was a
5 rationale for my approach to costing out different
6 components of the abatement plan.

7 Q. Understood. And as we discussed, there
8 have been a number of media campaigns, and
9 specifically in West Virginia, with respect to
10 opioid and drug education.

11 Did you do any research or analysis or
12 speak to anyone in Cabell County/Huntington and ask
13 them if they were, in fact, unaware of the dangers
14 of using illicit opioids and the potential risk of
15 using prescription opioids?

16 A. I --

17 MR. BURNETT: Objection, asked and
18 answered.

19 A. Yeah, I --

20 Q. I mean, this all -- this assumes, Doctor
21 Alexander, that the people in Cabell
22 County/Huntington are not aware of the risks of use
23 of opioids, whether they're illicit or prescribed
24 by a doctor?

1 MR. BURNETT: Objection, asked and
2 answered.

3 A. When you have the damage and the harms at
4 the level that has occurred within these
5 communities, I think that some measure of
6 investment should be made in public and patient
7 education.

8 I simply think - based on my
9 professional experience - that it would not be
10 smart to plan an abatement program that doesn't
11 further invest in this. And you know, it's one
12 thing to say that people know about the epidemic.
13 I mean, I'm not naive enough to think --

14 As I've said, I imagine that every
15 person in the County knows somebody that's been
16 impacted or they themselves have been impacted. So
17 I'm not suggesting that people have their head in
18 the sand.

19 But the bottom line is that this is a
20 complex epidemic; it has unfolded despite what we
21 might call sort of global awareness for years, and
22 this type of -- and this education just isn't just
23 about -- it's not as if there's one message, like
24 "Opioids can hurt you; be careful that you need

1 them if you take them."

2 So I think that it is very important
3 that any intervention, any abatement program,
4 includes further investment in this domain.

5 Q. And I guess my question in response to
6 that, Doctor Alexander, is: Isn't it a good idea
7 when you're formulating and proposing an abatement
8 plan to see whether or not there's an unmet need in
9 that particular community?

10 And you haven't done that here. Isn't
11 that true?

12 MR. BURNETT: Objection. Outside the
13 scope.

14 A. Yeah, I did not perform a comprehensive
15 needs assessment that included collecting primary
16 data from individuals residing within the County.
17 And frankly, if it's helpful for the courts to do
18 so and if the attorneys would like me to, I'm happy
19 to.

20 But I can assure you that there is
21 still stigma. I can assure you that there is still
22 -- I mean, I recall a conversation with -- that
23 took place with a family of -- a father who had
24 lost his son who blamed the son and said it was all

1 his fault.

2 Q. Let's --

3 A. And that --

4 MR. BURNETT: Counsel, please, don't
5 interrupt the witness, please.

6 MS. GEIST: I'm running out of time,
7 though, Counsel, so I'm trying to -- let's get to
8 --

9 MR. BURNETT: That's -- he's answering
10 your question. You can't cut him off when he's
11 answering your question.

12 A. And so this father was blaming the son from
13 having died from opioids, and if that's not stigma,
14 I don't know what is, thinking that this is bad
15 choices, that "My son just made a bunch of bad
16 choices, that he should have known better."

17 So I just -- I feel passionately about
18 this, that there have to be investments made in --
19 in correcting misconceptions and in improving
20 general awareness and knowledge among patients in
21 the general public about the contours of the
22 epidemic.

23 And -- but again, I was not asked to
24 do a specific comprehensive evaluation of attitudes

1 or beliefs on the ground.

2 Q. Right. You weren't -- you didn't do -- you
3 weren't asked to, but you didn't make the
4 assessment of: What are the actual unmet needs in
5 this community that would need to be addressed
6 through your plan that have not already been
7 addressed by the numerous interventions and
8 programs that Cabell County/Huntington has put in
9 place since at least 2015. Correct?

10 MR. BURNETT: Objection, asked and
11 answered.

12 A. So my plan was not to -- to add on the
13 margin. I was not asked to -- no one asked me to
14 come in and figure out what exactly is being done
15 and then to add on exactly what I thought was
16 necessary to reach an adequate program.

17 I wasn't asked to figure out where
18 that line lies for each of these categories, and so
19 it may well be that there is widespread investment
20 in -- in education that's already been made. I
21 would have lots of questions that I would want to
22 answer in order to understand whether I think those
23 are adequate.

24 But even if they are adequate, it's --

1 I wasn't asked to figure out if they're adequate
2 and then add on a little bit more. I was asked
3 what I think constitutes a comprehensive abatement
4 program.

5 Q. We can move on to Safe Storage and Drug
6 Disposal, please. And that's page 24 of your
7 expert report, Doctor Alexander.

8 A. Sure.

9 MS. GEIST: Okay, thank you very much,
10 John.

11 So here, Doctor Alexander, you state
12 that one of the things that needs to be done as
13 part of this intervention is to address the, quote,
14 "enormous stockpiles of opioids in homes within the
15 Community," meaning Cabell County/Huntington. Do
16 you see where I'm reading?

17 A. Yes.

18 Q. What evidence do you have that today there
19 are enormous stockpiles of opioids in homes in
20 Cabell County/Huntington?

21 A. Well, when you have millions of
22 prescriptions being provided into a community,
23 these prescriptions don't all end up -- they're not
24 all used.

1 I mean, we can all think about our own
2 homes and our own bathroom cabinets or bedroom
3 nightstands and I would bet dollars to doughnuts
4 that all of us have unused prescriptions somewhere
5 in our house, or many of us.

6 And so again, I didn't perform a
7 comprehensive review of the -- I didn't do a
8 household survey or some other assessment door to
9 door of the numbers of families that have unused
10 opioids, but in my professional judgment, there are
11 large numbers of unused opioids that are sitting in
12 kitchen cabinets and bedroom nightstands across
13 this and other communities in West Virginia.

14 Q. Well, with respect to unused opioids,
15 Doctor, a couple questions. One, there have been a
16 number of national DEA take-back days to address
17 this problem. Is that true?

18 A. Yes, it is.

19 Q. And there is - as I'm sure you know -
20 another one scheduled for October of this year.
21 Are you aware of that?

22 A. I wasn't aware of the particular
23 scheduling, but I'm pleased to hear that there will
24 be one.

1 Q. Yeah, there'll be another DEA national
2 take-back day in October of this year. And Cabell
3 County has two permanent collection sites for
4 unused prescription medications now, correct?

5 A. I believe so.

6 Q. Now -- but my question is, Doctor
7 Alexander, if a patient ends up with leftover
8 pills, more pills than he or she needed for
9 whatever the condition was that they received the
10 prescription in the first instance, why did they
11 get more than they needed?

12 MR. BURNETT: Objection, calls for
13 speculation.

14 A. It's a great question, and opioids have
15 been oversupplied, and in some instances, it's
16 prescriptions that shouldn't have been originated
17 in the first place; and in other instances, it's
18 the dose or the -- the duration.

19 And -- and frankly, you know, like
20 many medicines that are used to treat conditions
21 such as pain, pain can resolve, and it's an
22 imperfect science to know the exact number of pills
23 that someone needs.

24 Q. Who determines how many pills are

1 prescribed to that patient?

2 A. Another great question, and we're back to
3 my -- my earlier reply, that we have prescribers;
4 we have patients; and then we have the factors that
5 drive their behaviors. And so most immediately,
6 you have prescribers, and in many cases patients,
7 that in more cases than not, I hope, are reaching
8 shared decisions about how to manage pain in this
9 instance.

10 And then you have all the -- all the
11 potential influencers of prescribers and patients.

12 Q. So the answer to my question was -- I asked
13 you, who is the one who prescribed the medication
14 in the first instance? Who is the one who decides
15 whether it's 10 pills, 30 pills or 90 pills? Who
16 decides how many times a day the patient should be
17 using that medication? Who makes that decision?

18 A. Yeah, and I'm sorry, I --

19 MR. BURNETT: Objection. Objection,
20 asked and answered.

21 A. I'm sorry I can't give you a kind of
22 one-word answer, but I would say it's the
23 prescriber; it's the patient. And they exist
24 within a number -- they exist within a sphere --

1 there's sort of a sphere of influence, and they're
2 drivers of their behavior.

3 Q. So it's the doctor and the patient.

4 A. And the factors that influence their
5 behaviors.

6 Q. Now, you also state that diversion -- we've
7 talked a little bit about this before. Diversion
8 of prescription opioids occurred because of the
9 failure to safely store and dispose of the unused
10 opioids. So if somebody has leftover pills,
11 there's a failure to store it and there's a failure
12 to dispose of it.

13 And whose failure is that? Who is the
14 one who doesn't dispose of or store unused opioids?

15 MR. BURNETT: Objection.

16 A. Well, I mean, ultimately the -- in these
17 instances where we're talking about the potential
18 for diversion or for nonmedical use, we're
19 considering patients or -- that have received
20 prescriptions and so --

21 I suppose in some narrow sense, you
22 could say that patients are on the hook. But
23 again, patients are -- you know, patients need to
24 be empowered and equipped with appropriate

1 knowledge, and if patients believe that opioids are
2 no big deal, that they work great, that they're not
3 addictive, that as long as you have organic pain,
4 you won't -- need not worry about addiction - which
5 is something that I was taught as a resident and as
6 a young physician - if that's what I'm
7 communicating to my patients, then my patients are
8 totally misinformed about how they should be
9 storing and -- and disposing of these products.

10 Q. Quickly moving on to Harm Reduction, page
11 68 of your report.

12 A. Sure.

13 MR. BURNETT: Which -- I'm sorry,
14 which page?

15 MS. GEIST: 68.

16 A. Okay.

17 Q. Oh, I'm sorry, I'm sorry. I'm looking at a
18 different number. 28.

19 MS. GEIST: I apologize to everyone
20 and to John. It's the end of a long day.

21 Q. Page 28. I apologize, Doctor. Harm
22 Reduction. So here at page 28, one of the things
23 you are suggest is the addition of a syringe
24 services program or an SSP; is that correct?

1 A. Yes, although I think we've already
2 discussed that I think Cabell County and the City
3 of Huntington have done a laudable job in
4 developing a syringe program.

5 Q. They were the first in West Virginia to
6 implement an SSP or a safe needle, clean needle
7 exchange program; is that right?

8 A. Yes, I believe so.

9 Q. And just to be clear, this program -- 100
10 percent of the services of this program is provided
11 to people who inject drugs. True?

12 A. As opposed to -- who else would they -- as
13 opposed to who else?

14 Q. I'm just asking you to confirm. The only
15 individuals who would be serviced by the Syringe
16 Services Program or the needle exchange program are
17 people who inject drugs, meaning people who use
18 drugs illegally. Correct?

19 A. Yeah, I --

20 MR. BURNETT: Object.

21 A. Yes, yes. I mean, I suppose theoretically
22 they might, you know, be willing to engage with
23 someone that has addiction if they're not -- if
24 they're doing, for example, Hepatitis C screening

1 and they have a mobile van, I don't think they
2 would turn you down if you say, "Hey, can I get
3 screened? But I'm not currently using needles."

4 But yes, they're designed to focus on
5 people with intravenous drug use.

6 Q. Now, in terms of your proposal here, in
7 connection with your recommendations, did you
8 research the history of needle exchange programs or
9 SSPs in West Virginia and Cabell County?

10 MR. BURNETT: Objection.

11 A. To the degree that it's discussed in my
12 report or referenced in my report, yes, I did.

13 Q. Okay. So you are aware that as of the end
14 of last year, there were 18 syringe services
15 programs in West Virginia, but two programs had
16 been closed by local government, including the one
17 in the City of Charleston. You're aware of that?

18 MR. BURNETT: Objection.

19 A. I was not aware of the exact number of
20 programs opening and closing, no.

21 Q. Okay. Do you know why the SSP in the City
22 of Charleston was closed down by the local
23 government?

24 A. No, I do not.

1 Q. I want to quickly --

2 MS. GEIST: Actually, let me ask the
3 videographer how many minutes I have left, only
4 because I need to be considerate of counsel for the
5 other defendants who might be on the call or on the
6 video and would like to ask a question.

7 VIDEO OPERATOR: Hold for one moment
8 so I can add it all up. The time is 5:58. We are
9 now going off the record.

10 (A discussion was had off the record
11 after which the proceedings continued
12 as follows:)

13 VIDEO OPERATOR: The time is 5:59, we
14 are now back on the record.

15 BY MS. GEIST:

16 Q. Doctor Alexander, in terms of your cost
17 estimate for your Safe Storage and Drug Disposal
18 recommended programs --

19 A. Yes.

20 Q. -- I'm looking at your redress model, if
21 you have that in front of you.

22 A. Yes, I do. So I think that's Tab 1C.

23 Q. It is. Thank you. And it appears that you
24 have based a cost estimate on this particular

1 intervention on -- on a program that was in King
2 County, Washington and a program that was in
3 Alameda County in California.

4 Is that correct?

5 A. Yes, ma'am.

6 Q. And were both of these programs SSPs?

7 A. I believe these are safe storage and drug
8 disposal programs.

9 Q. Okay. Any reason why you didn't base your
10 cost estimate on the local jurisdiction in West
11 Virginia, given the fact that there have been 18
12 SSPs in the state to date?

13 A. Again, here, this is a different abatement
14 category than syringe service programs. Syringe
15 service programs are focused on providing services
16 for people using drugs intravenously, and this
17 category is focused on trying to improve the safe
18 storage and drug disposal processes and programs in
19 the County and the City of Huntington.

20 Q. But again, there have been safe storage and
21 drug disposal programs in the City of Huntington
22 and in Cabell County, correct?

23 A. Pretty modest. I mean, I think you
24 mentioned that there have been two, and frankly, it

1 should be no more difficult to get rid of an unused
2 opioid than it is to get the prescription in the
3 first place.

4 And so, you know, these -- these boxes
5 and these storage facilities should be -- or
6 storage containers and disposal containers - really
7 is what we're talking about here - these should be
8 available in pharmacies and clinics, doctors'
9 offices.

10 You know, you can't just put them in
11 one or two sheriffs' departments or, you know, the
12 police department of Milton and expect that you're
13 gonna take care of the oversupply in the County.

14 So my point is that they should be
15 scaled up. And in direct response to your question
16 regarding the sources of costs, I would just
17 highlight the point that I made earlier about the
18 step-wise approach that we used. We used local
19 costs whenever possible and triangulated these
20 costs with experts that we spoke with.

21 When local costs weren't available, we
22 used regional or national costs. And this is also
23 a nice example where we took the average of two
24 programs. It just so happens that they yield

1 fairly similar estimates of the costs of drug
2 storage and disposal programs. But we did look
3 carefully and thoroughly at different potential
4 sources of this information.

5 Q. Are you -- thank you for that. You had
6 mentioned the two DEA-based take-back programs that
7 I had mentioned. Are you aware that funding from
8 the substance abuse prevention and treatment block
9 also granted take-back activities specifically in
10 the state of West Virginia?

11 A. I'm not aware of the details of that, but
12 my sense - and again, I'd want to look at the
13 source materials for, you know, more particular
14 information, but my sense is that there are
15 opportunities to scale up take-back programs and
16 safe storage programs within the community.

17 Q. Are you aware of any information that the
18 national and state-based take-back programs
19 implemented in West Virginia have been inadequate
20 to address the needs of the community?

21 A. Well --

22 MR. BURNETT: Objection.

23 A. -- globally -- again, I wasn't asked to add
24 only the margin, so none of my efforts are based on

1 some assessment and conclusion about sort of the
2 marginal need for additional effort, but I -- I
3 would be amazed -- I mean, I simply would be very
4 surprised in my professional judgment if -- if
5 there are not opportunities to further improve the
6 safe storage and disposal of prescription opioids
7 in Cabell County and the City of Huntington.

8 Q. Let's talk about your suggestion to put in
9 place an opioid abatement coordinating unit.

10 A. Sure.

11 Q. And that appears to be a separately-named
12 unit that would have a director, two data analysts
13 and 0.5 staff assistants. I'm not sure what that
14 means.

15 A. Just half of somebody.

16 MR. BURNETT: Counsel, where are you
17 getting that information from?

18 MS. GEIST: That's under the 1F
19 section, Surveillance, Evaluation and Leadership.

20 Q. And that is your suggestion, Doctor
21 Alexander, that there be something called an Opioid
22 Coordinating Abatement Unit?

23 A. Well, let's see. So the tab I'm looking at
24 is Surveillance, Evaluation and Leadership. I see.

1 Yeah, I don't think that it's so important what
2 it's called, but the point is that I think that
3 there is -- that this type of program has to have
4 coordination and leadership and evaluation, and
5 that I have built in some of those costs
6 conservatively into my program.

7 Q. You have been involved in a -- in the
8 review and research of a number of different
9 interventions and programs, I imagine, throughout
10 the United States to address the substance use
11 crisis in the U.S. True?

12 A. Well, they focused on the opioid epidemic,
13 but yes, I have.

14 Q. All right. Can you -- can you name for me
15 any area in the country that has not had as much
16 leadership, coordination and surveillance as we
17 have seen in Cabell County/Huntington?

18 A. I was confused by the construction of the
19 question. Can you ask again, please?

20 Q. Sure. I assume you would agree with me
21 that there has been extensive coordination and
22 leadership in Cabell County with respect to the
23 communication of information, as you -- you discuss
24 here in this section of your report.

1 A. I think there's been a tremendous
2 mobilization, yes.

3 Q. And you talk about this. Paragraph 86, you
4 say, "Fortunately, the City of Huntington, through
5 the early initiatives of the Mayor Williams' Office
6 of Drug Control Policy," "recognized the need for
7 timely and comprehensive data from the community to
8 guide early measures and initiatives, including:"
9 "(LEAD);" "Cabell Drug Court; Lily's Place;"
10 "Recovery Point; Huntington Quick Response Team;"
11 "and the Harm Reduction Program at" Cabell
12 Huntington Health Department.

13 Do you see where I am?

14 A. Yes, I do.

15 Q. So my question was: It doesn't get much
16 better than this in terms of coordination. Would
17 you agree with me on that?

18 A. Well --

19 MR. BURNETT: Objection.

20 A. Again, I wasn't asked to perform a
21 comprehensive evaluation of what's been done to
22 date, and nor is -- nor is my abatement program
23 based on some margin that needs to be added on to
24 that.

1 So you know, this type of program
2 could well sit within the mayor's office. I don't
3 have an -- I wasn't asked, or I didn't provide an
4 opinion about where this should sit. I'm merely
5 stating that I think that any abatement program -
6 if it's going to be effective - needs to have some
7 resources devoted to the types of functions that I
8 articulate in paragraphs eighty -- 85 to 92. 85 to
9 92.

10 So I talk about data integration; data
11 harmonization; I talk about needs assessments; you
12 know, data linkages. You know, there's lots of --
13 so I think that there's more good work to be done,
14 but I don't want to diminish the laudable efforts
15 that have been done under enormous constraints thus
16 far in the community.

17 Q. Well, and they already have - in addition
18 to the programs we already mentioned and discussed
19 - they already have -- as you do acknowledge in
20 your report, there is the ability to monitor fatal
21 and nonfatal overdoses in realtime using the
22 overdose detection mapping system, and there's also
23 Marshall University Data Dashboard, and the West
24 Virginia Office of Drug Control Policy apparently

1 recently launched an interactive opioid Data
2 Dashboard and has monthly transfer EMS calls, some
3 of which we discussed earlier.

4 That's all in place already, correct?

5 MR. BURNETT: Objection.

6 A. Some of that is in place. I think in
7 Paragraph 91, I articulate my vision for the role
8 of this group, and I would submit while I was --
9 while I was not asked to perform a comprehensive
10 evaluation of the services to date, I would submit
11 that in Paragraph 91, these areas that I call out,
12 one -- four different points, I think that there
13 are opportunities to further strengthen the
14 performance of the leaders within the mayor's
15 office and elsewhere within the community that are
16 fulfilling these functions.

17 Q. Well, and you note -- following on your
18 Paragraph 91, you note that "the Community" -
19 meaning Cabell County/Huntington - has in fact "an
20 excellent function for data collection and
21 surveillance."

22 My original question to you was, as
23 somebody with experience in this area, can you
24 identify for us any other jurisdiction in the

1 entire United States that has a better -- that has
2 better data collection and surveillance available
3 to it other than Cabell County/Huntington?

4 MR. BURNETT: Objection, asked and
5 answered.

6 A. I mean, it's an interesting -- it's an
7 interesting question. I've not looked at every
8 community nationwide. Some of the communities that
9 I've examined, I've not been disclosed, and I don't
10 think I'm sort of, you know, privy to speak about.

11 I think that Cabell County has -- and
12 the City of Huntington have, you know, made very
13 laudable efforts, but I'm not comfortable, you
14 know, opining on the sort of -- the merits or the
15 magnitude of their efforts relative to other
16 communities.

17 Q. Okay. But on top of all these laudable
18 efforts - to use your own words - you would like to
19 add a Opioid Abatement Coordinating Unit, and you
20 would leave the costs of that, it looks like, to
21 Mr. Barrett. Is that correct?

22 MR. BURNETT: Objection.
23 Mischaracterizes the report.

24 A. Yeah, I'm not suggesting an addition of --

1 of -- again, I wasn't asked to figure out what
2 needs to be added to what is currently taking
3 place. I was asked to develop a longitudinal and
4 comprehensive program to substantially reduce
5 opioid-related harms over the next 15 years, and
6 that's what I've done.

7 Q. You are suggesting that there be put in
8 place an Opioid Abatement Coordinating Unit that
9 would be comprised of at least one director, two
10 data analysts, and a staff assistant. True?

11 A. Well, I don't think the name is as
12 important as the functions that they serve. So I
13 -- it doesn't matter to me -- I mean, first of all,
14 ultimately, the decisions will rest with the
15 community itself, right? So -- but this is merely
16 my professional judgment.

17 Secondly, it doesn't matter to me what
18 it's called. The point is that there are functions
19 that I think need to be fulfilled if the abatement
20 program is to be successful, and I'd like to just
21 briefly call out again Paragraph 91 where I
22 articulate the types of roles that this type of
23 unit, for lack of a better word, the roles that
24 this unit could serve.

1 Q. Why would -- Doctor Alexander, you've said
2 --

3 MR. BURNETT: Hold on, he wasn't
4 finished with his answer.

5 MS. GEIST: This --

6 Q. I am using your language. You have termed
7 this new group that you think should be
8 implemented, the quote, "Opioid Abatement
9 Coordinating Unit," end quote. That's what you
10 call it, correct?

11 A. That's -- again, it doesn't matter to me
12 what it's called. But what I was going to say in
13 response to your last query was: I would wager if
14 we asked Mayor Williams, you know, his beliefs
15 about sort of would it be helpful to have
16 additional resources to fulfill the functions that
17 I've articulated in Paragraph 91, I would be
18 surprised if he said "No."

19 Maybe he would. But the point is that
20 it doesn't matter to me what it's called; the
21 functions that I'm talking about are improving the
22 timeliness, quality, coordination and integration
23 of existing data streams.

24 I think that's very important.

1 Conducting opioid-specific surveillance activities.
2 Enhancing the accessibility, visibility and
3 shareability of data. And performing comprehensive
4 evaluations of interventions. And proposing
5 evidence-based recommendations.

6 I'm not aware that all of that is
7 being done currently, no.

8 Q. Now, did you attempt to calculate what
9 would be the incremental increased benefit if the
10 Opioid Abatement Coordinating Unit was established
11 in Cabell County/Huntington?

12 MR. BURNETT: Objection, outside the
13 scope.

14 A. I was not asked to evaluate the incremental
15 impact of the particular components that I
16 proposed, although all of them have scientific and
17 public health evidence base to support them.

18 Q. Where are the additional syringe services
19 programs or the SSPs -- where do you propose that
20 they be located in -- in the community?

21 A. Again, I'm not sure if you're referring to
22 syringe programs or take-back-

23 Q. Syringe services programs --

24 A. -- programs. Syringe services programs.

1 So --

2 Q. Yeah. You would like to have more SSPs in
3 the community, correct?

4 A. I would like continued investment in Harm
5 Reduction, and one important component of Harm
6 Reduction are syringe service programs.

7 Q. And so how many more syringe services
8 programs are you proposing be put into the
9 community?

10 A. Well, it's not the number of programs that
11 matters; it's the number of people that are
12 reached. And if we look at my redress models, I
13 articulate target populations year over year for
14 this and every other -- every other abatement
15 category.

16 So it's not -- I'm not suggesting we
17 need four more programs. The point is, we need to
18 scale up and reach more people that are currently
19 walking around using intravenous drugs who may have
20 Hepatitis C or HIV or may be transmitting it to
21 others or may need to get into treatment for opioid
22 addiction.

23 We need to reach those people.

24 Q. Are you aware that -- that at the present

1 time, the SSP or syringe services program, in the
2 City of Huntington or in Cabell County is limited
3 to its own citizens? That was --

4 MR. BURNETT: Objection.

5 Q. -- a decision and modification that the
6 community determined it needed to make, because
7 they had all different IV users coming into their
8 community and they didn't want that. Are you aware
9 of that?

10 MR. BURNETT: Objection.

11 A. That just reflects -- I mean, that reflects
12 the magnitude of unmet need and the resource
13 constraints. I mean, that's too bad -- I believe I
14 had heard that, and that's too bad to hear, because
15 you know, the last thing I think we want is for
16 people who have opioid addiction to be turned away
17 from treatment or from -- from harm reduction
18 services.

19 Q. In terms of treatment, I think we had
20 talked about that extensively before. I had a
21 couple more follow-up questions for you in terms of
22 the help lines. And I'm at page 42 of your report,
23 Doctor Alexander.

24 A. Okay. What -- what paragraph?

1 Q. I'm sorry, wait a minutes. Yes, page 42 of
2 your report, I was right.

3 A. What paragraph, please?

4 Q. Hold on, I'm looking. I apologize. I'm
5 back a couple pages. Sorry about that.

6 Page 34, please. And this relates to
7 Connecting Individuals to Care, Doctor Alexander.

8 A. Yes, ma'am.

9 Q. And you have in here a discussion on help
10 lines?

11 A. Yes.

12 Q. And that you think help lines should
13 essentially be expanded? Is that right?

14 A. As with the prior queries, I was not asked
15 to decide or to evaluate or make recommendations on
16 the margins, so what I am proposing is that any
17 abatement plan that's going to work needs to link
18 people to care and one of the mechanisms to do so
19 is a help line.

20 Q. Now, people in Cabell County are able to
21 call in to and get assistance through the help for
22 Virginia -- or HELP4WV, meaning help for West
23 Virginia, help line. Correct?

24 A. I believe that's the case, yes.

1 Q. And you note specifically here that there
2 have been a certain percentage of individuals from
3 Cabell County who have in fact utilized that
4 state-based help line. True?

5 A. Yes.

6 Q. Okay. And you also note that overall, it
7 appears there have been 41,000 individuals who have
8 used that help line to get connected to treatment
9 options. True?

10 A. Yes.

11 Q. And it appears that 40 percent of the users
12 of the hotline or the callers to the hotline had
13 reported using opioids. Is that right?

14 A. Yeah, that was the most commonly-used
15 substance among the help line callers.

16 Q. And of course, 40 percent of opioid users
17 doesn't tell us whether they were using illicit
18 opioids like heroin or fentanyl or carfentanil,
19 true?

20 A. Correct.

21 Q. We don't have any indication or any
22 information that anyone calling that hotline was
23 using prescription opioids as -- as provided by a
24 physician. True?

1 A. I'm not aware of that -- that that
2 information exists, correct.

3 Q. And I assume you will agree with me - doing
4 this simple math - if 40 percent of the callers are
5 calling because of their use of opioids and 60
6 percent of the callers are calling about some other
7 type of drug for which they are seeking treatment
8 such as methamphetamine or cocaine -- true?

9 MR. BURNETT: Objection.

10 A. Or -- or alcohol or marijuana or -- could
11 be, yeah.

12 Q. In other words, the vast majority of the
13 individuals calling the help line, HELP4WV, were
14 calling about some other substance other than
15 opioids. That's just mathematically correct.
16 Right?

17 MR. BURNETT: Objection.

18 A. Well, those are your words, not mine. I
19 would characterize it as two out of five were
20 calling pertaining to opioids and three out of five
21 were not.

22 Q. Now, in terms of -- you have a program
23 designed to address job training?

24 A. Yes.

1 Q. Is that right, Doctor?

2 MR. BURNETT: Let me just interrupt.
3 It's been seven hours, so I would say, you know,
4 ask your last question and then we should wrap up
5 here.

6 Q. Is it your opinion, Doctor Alexander, that
7 job training is going to result in employment for
8 individuals with opioid use disorder or substance
9 use disorder?

10 A. I think it can help to address one of the
11 -- you know, one important contributor to the
12 epidemic, which has been, you know, a lack of --
13 lack of gainful employment opportunities.

14 But as I noted at the outset, the
15 epidemic isn't just about biology or environment;
16 it's also about access and supply.

17 Q. And individuals who are in need of job
18 training, I assume you will agree with me, many
19 need that job training because of issues unrelated
20 to opioid use disorder such as mental health
21 problems, lack of education, lack of a high school
22 degree, or issues relating to substance -- mental
23 health disorders. True?

24 A. Yeah, there could be complex determinants

1 of joblessness, but I think in order to make
2 success in addressing opioid addiction, one needs
3 to work to expand employment opportunities.

4 People need jobs. People need
5 livelihoods. And it's only reasonable to expect
6 that a successful program is going to help provide
7 those.

8 Q. And do you have any idea that if these job
9 training programs are implemented, as you're
10 suggesting, that there are businesses in Cabell
11 County that have job openings for these
12 individuals?

13 A. Well, it's a great question, and it speaks
14 to the broader economic opportunity -- the
15 important dimension that economic opportunity plays
16 in helping to create a better future for this
17 community.

18 So I don't know specifically -- I was
19 not asked to do a specific estimate of the number
20 of employment opportunities in the County or the
21 City of Huntington.

22 Q. But you know from The City of Solutions
23 document that we went through together that the
24 community itself acknowledges that because of the

1 economic -- socioeconomic challenges and issues in
2 the region, that there are bigger issues
3 challenging that area in terms of job employment
4 and things of that nature.

5 A. Well, The City of Solutions document is one
6 of hundreds of documents that I reviewed, and it
7 was performed at one point in time. But I
8 certainly can agree with you that -- that
9 joblessness and absence of economic opportunity is
10 -- is one of many important facets of the opioid
11 epidemic and the way that it's uniquely affected
12 this rural Appalachian community.

13 MR. BURNETT: Counsel, we've now gone
14 over seven hours. We need to stop for the day.

15 MS. GEIST: That's fine. I'm done.
16 Thank you for your time, Doctor Alexander.

17 THE DEPONENT: Thank you.

18 VIDEO OPERATOR: The time is 6:25. We
19 are now going off the record. This concludes the
20 deposition.

21 (Having indicated he would like to
22 read his deposition before filing,
23 further this deponent saith not.)

24 --oOo--

1 STATE OF WEST VIRGINIA,
2 COUNTY OF JACKSON, to wit;

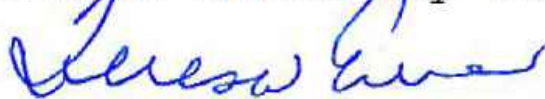
3
4 I, Teresa S. Evans, a Notary Public within
5 and for the County and State aforesaid, duly
6 commissioned and qualified, do hereby certify that
7 the foregoing deposition of DR. G. CALEB ALEXANDER
8 was duly taken by me and before me at the time and
9 place and for the purpose specified in the caption
10 hereof, the said witness having been by me first
11 duly sworn.

12 I do further certify that the said
13 deposition was correctly taken by me in shorthand
14 notes, and that the same were accurately written
15 out in full and reduced to typewriting and that the
16 witness did request to read his transcript.

17 I further certify that I am neither
18 attorney or counsel for, nor related to or employed
19 by, any of the parties to the action in which this
20 deposition is taken, and further that I am not a
21 relative or employee of any attorney or counsel
22 employed by the parties or financially interested
23 in the action and that the attached transcript
24 meets the requirements set forth within article
twenty-seven, chapter forty-seven of the West
Virginia Code.

My commission expires October 25, 2020.
Given under my hand this 22nd day of September,

~~GIVEN UNDER MY HAND~~



Teresa S. Evans
RMR, CRR, RPR, WV-CCR

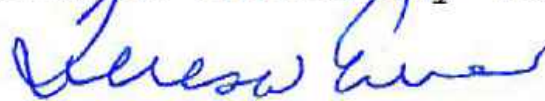
1 STATE OF WEST VIRGINIA

2 COUNTY OF KANAWHA, to wit;

3 I, Teresa Evans, owner of Realtime Reporters,
4 LLC, do hereby certify that the attached deposition
5 transcript of DR. G. CALEB ALEXANDER meets the
6 requirements set forth within article twenty-seven,
7 chapter forty-seven of the West Virginia Code to
8 the best of my ability.

9
10 Given under my hand this 22nd day of September,
11 2020.

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15 GIVEN UNDER MY HAND

16 

17 Registered Professional
18 Reporter/Certified Realtime Reporter
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September 23, 2020

To: David D. Burnett, Esquire

Case Name: City of Huntington v. Amerisourcebergen Drug Corporation

Veritext Reference Number: 4241658

Witness: Dr. G. Caleb Alexander Deposition Date: 9/18/2020

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

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DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4241658

CASE NAME: City of Huntington v. Amerisourcebergen Drug Corporation, et al.

DATE OF DEPOSITION: 9/18/2020

WITNESS' NAME: Dr. G. Caleb Alexander

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

10/08/2020

G. Caleb Alexander

Date

Dr. G. Caleb Alexander

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4241658

CASE NAME: City of Huntington v. Amerisourcebergen Drug Corporation, et al.

DATE OF DEPOSITION: 9/18/2020

WITNESS' NAME: Dr. G. Caleb Alexander

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

Date

Dr. G. Caleb Alexander

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 4241658

PAGE/LINE(S) / CHANGE /REASON

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Date Dr. G. Caleb Alexander

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20____.

Notary Public

Commission Expiration Date

[& - 2035]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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